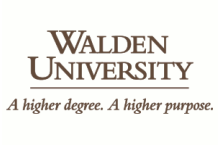

2020

Service Members With Posttraumatic Stress Disorder who Face Employment Challenges Postdeployment

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Walden University
2020

Abstract

Service Members With Posttraumatic Stress Disorder Who Face Employment Challenges Postdeployment

by

Donna Scurlark Sargent

MS, Jacksonville State University, 1997

BS, Jacksonville State University, 1982

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

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October 2020

Abstract

The Iraq War was the longest war in the history of the United States, involving over 2 million service members. Service members who served in Iraq or Afghanistan experienced a high rate of mental health disorders including posttraumatic stress disorder (PTSD), depression, and substance abuse as they returned from deployment. Research is lacking in regard to how Army reservists and National Guardsmen function at home, school, work, and in the community upon their return from service. The purpose of this qualitative hermeneutic phenomenological study was to explore the lived experiences of service members with PTSD who experienced challenges with work reintegration. Social constructivist theory was used as a lens through which data were viewed. Data were gathered through audio-recorded, semistructured interviews with 6 service members from Alabama, both males and females. Four themes emerged: reexperiencing the trauma, reconnecting with others, difficulty performing or maintaining employment, and a need for knowledge among counselors to develop best practices. It is recommended that the military, employers, and counselors provide better training, treatment, and support for returned service members through the development of (a) a veterans' advisory board, (b) a peer support group for veterans and their spouses, (c) a veterans' peer consulting group to work with employers, (d) a time bank for veterans, and (e) quarterly roundtables for the community and veterans. The implementation of these services could improve the employment reintegration and overall quality of life of returning service members with PTSD.

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Dedication

This dissertation is dedicated to all veterans and their families involved in Operation Enduring Freedom and Operation Iraqi Freedom who have selflessly sacrificed their lives to ensure the safety of all individuals who live in the United States of America. Thank you for your tireless service. God bless you all.

Acknowledgments

This finished work was made possible because of all the people who have supported me on my journey. There is an African proverb that says “It takes a village to raise a child.” I say it takes a multitude of caring supportive people to complete a dissertation. First, I must give glory and honor to God who has kept me during this journey. I am grateful to my dissertation committee. My chair, Dr. Corinne Bridges, has been a blessing to me. She has worn many hats during this period in my life; her official role was my methodologist, but she has been my sounding board, a counselor, and good kicker when I needed a proverbial stiff kick in the rear end. She has kept me on task and has been a source of encouragement when needed. Thank you, Dr. Bridges, for your commitment to helping me finish my course. Dr. Walter Frazier has served as my content expert, and he has been a great source of support through the dissertation group he formed for doctoral students in the dissertation stage of their program. Thank you, Dr. Frazier. Thank you, to my URR, Dr. Jason Patton. I want also thank Dr. Nancy Fox for her support, encouragement, and the resources she provided me during the proposal phrase of my dissertation and throughout the dissertation process. Dr. Jerry Kiser was also a tremendous source of support and encouragement to me, always ending our conversation with his parting words, “I look forward to calling you Dr. Sargent.” Thank you, Dr. Kiser. Thank you to Mrs. Rena Ramsey who has been my technical support whenever I got stuck in a place I could not figure out she was there. Thank you, Rena. Thanks to my grandson, Justin, for the countless hours he spent running to the copier to bring me articles and resources for my research. My final acknowledgment is to my

husband who has been a tremendous source of support and encouragement to me. He has sacrificed as many years as I have in pursuing this doctorate. Thank you, John; I love you.

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Chapter 1: Introduction to the Study

The impact of the Iraq War (2003-2011) has been profound on U.S. service members and their families (Burke, Degeneffe, & Olney, 2009). Service members are experiencing reintegration issues with parenting, marital and partner relations, social and civic functioning, legal concerns, homelessness, financial stability, and employment (Burke et al., 2009; Meis, Erbes, Polusny, & Compton, 2010; Wehman, Gentry, West, & Arango-Lasprilla, 2009). As service members return home, it is evident that their levels of functioning as civilians are impacted by a lack of accessible mental health care, social supports, and economic resources (Wehman et al., 2009).

Posttraumatic stress disorder (PTSD) is the most common mental health disorder for which service members seek disability benefits (Murdoch et al., 2011). Yet, few evidence-based programs exist that promote successful work reintegration for service members with PTSD who are reservists or guardsmen (Blevins et al., 2011). Service members with PTSD face many challenges (adjusting to time zone change, learning new equipment and work policies and procedures) when reintegrating into the civilian workplace (Til et al., 2013). The perceptions of these veterans about these challenges are unknown, based on my review of the literature. Knowledge of the perceived barriers to employment that service members face postdeployment may increase understanding for mental health counselors. This knowledge could inform treatment practices, counselor education, and the development of programs to assist with the successful workplace reintegration of returning service members with PTSD. In this chapter, I provide an overview of the research study, beginning with the background. The next section

includes the problem as identified in the gap in the literature, followed by the purpose of the study, the research questions, and the conceptual framework. A brief description of the nature of the research and the methodology is also given. Chapter 1 also includes operational definitions; discussion of the assumptions, scope and delimitations, limitations, and significance of the study; and a summary.

Background

PTSD has been well documented in veterans of the Vietnam War. Its symptomology affected Vietnam veterans as they sought to regain control over their lives (Walker, 2010). Combat is a commonality among service members returning home with PTSD (Walker, 2010); as such, mental health professionals continue to be concerned about PTSD in service members who have engaged in more recent U.S. conflicts. Tennant (2012) examined data from the Current Population Survey conducted by the U.S. Bureau of Labor Statistics and U.S. Census Bureau. Her study revealed that disabilities were increasing for veterans returning from Iraq and Afghanistan who had experienced combat-related injuries (Tennant, 2012). The injuries identified in this study were physical injuries, traumatic brain injury (TBI), hearing loss, PTSD, and a combination of ailments and injuries (Tennant, 2012). As Tennant noted, there is a need for more research to determine the various types of disability payments provided to service members and employment outcomes. The purpose of this study was to gain insight on the impact of injuries sustained in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) on service members regarding independent living, work limitations, and cognitive disabilities.

Researchers have discussed the need for specialized care for service members who have the signature injuries of TBI and PTSD from the Iraq War. This specialized care would involve rehabilitative services and behavioral and physiological care for service members who incurred combat TBI and PTSD injuries (Burke et al., 2009). Burke et al. (2009) found that 22% of OIF service members have some type of brain injury and one in five service members who deployed to Iraq have developed PTSD. The researchers recommended further research for rehabilitation counselors and the veterans' system to identify common barriers to societal reintegration among service members who sustain TBI/PTSD injuries (Burke et al., 2009).

Interian, Kline, Callahan, and Losonczy (2012) conducted a study with National Guard soldiers to explore and identify common readjustment stressors that returning service members experience. The stressors identified included marital, familial, and employment issues (Interian et al., 2012). Many of the soldiers returning had some type of mental health issue; however, it was estimated that 23-44% of the soldiers had PTSD (Interian et al., 2012). Although Interian et al.'s findings indicated that many of the soldiers did not seek treatment within the first year, the increase in PTSD cases has become a national priority and has expanded the time Guard members are eligible for treatment. In addition to revealing that common stressors were a predictor of the need for treatment, Interian et al.'s findings showed that service members were more likely to seek treatment if they received encouragement.

Til et al. (2013) conducted a comprehensive literature review to explore what data existed regarding ways to assist service members with mental disorders reintegrate into

the civilian workplace postdeployment. Til et al. categorized work in three different ways: return to work (RTW), supported employment, and reintegration. The comprehensive literature review revealed limited knowledge about how to reintegrate individuals with mental disorders into the workforce; it further indicated a need for research on factors to assist with reintegration of service members with mental disorders back into the civilian workforce (Til et al., 2013).

Zatzick et al. (2008) conducted a major study with 2,702 participants recruited from 69 hospitals across the United States to examine the impact of PTSD and depression on the functional and return to work outcomes of patients. Zatzick et al. examined PTSD and depression; functional, work, and productivity outcomes; activities of daily living; medical outcomes; and productive activity and work. The researchers predicted that patients with one of the disorders would be three times as likely not to return to work; those patients with both disorders were six times as likely not to return to work (Zatzick et al., 2008).

These findings are relevant to this hermeneutic phenomenological study as they demonstrate the need to explore further how service members with PTSD can benefit from the assistance of professionals who know how to help them in the work reintegration process. I aimed to fill gaps currently in the literature regarding work reintegration. There is a need for qualitative studies on employment challenges of service members. This phenomenological study could inform counselor educators on how to train counseling students in best practices for this population.

Problem Statement

The impact of the Iraq War has been profound with over 2 million U.S. service members who deployed to Iraq or Afghanistan (Sayer et al., 2010). Research has indicated that mental health disorders and symptoms including PTSD, depression, and substance abuse are high among service members within their 1st year of returning after deployment (Sayer et al., 2010). Reports revealed high rates of marital and occupational difficulty after serving in Iraq and Afghanistan (Sayer et al., 2010). According to Sayer et al. (2010), research was needed regarding postdeployment health problems among Iraq-Afghanistan service members to assist in the development and resourcing of health services as there is a lack of information about service members who are not active duty. Nonactive duty service members face unique circumstances after returning from deployment, yet little is known about how these service members function after deployment at home, school, and work (Sayer et al., 2010). A study on the consequences of PTSD on service members' work and quality of life revealed work impairment among service members with PTSD but not in service members without the disorder (Vogt et al., 2016).

Few evidence-based programs exist that promote successful work reintegration for service members with PTSD who are reservists or guardsmen (Blevins et al, 2011). Service members with PTSD face many challenges reintegrating back into the civilian workplace (Til et al., 2013). The perceptions of these veterans concerning these difficulties are unknown, based on my review of the literature. Research on the perceived barriers that service members face and their subjective lived experiences may increase

understanding for mental health counselors. A better understanding of the identified barriers and lived experiences and perceptions of service members with PTSD who face employment reintegration challenges could help counselor educators determine the necessary skills to assist these service members in regaining a sense of purpose through work. This empirical knowledge may help clinicians identify skills to help service members or support counselor educators in training counselors to work effectively with the growing population of returning service members with PTSD who need help to successfully reintegrate in the workplace.

Purpose of the Study

The purpose of this hermeneutic phenomenological study was to understand the lived experiences of service members with PTSD who experience employment reintegration challenges. Hermeneutic phenomenology focuses on bringing meaning and understanding to the lived experiences of people (Kafle, 2011). In hermeneutic phenomenological studies, the subjectivity of the participants is valued (Cohen, Khan, & Steeves, 2000). I used a hermeneutic phenomenological approach to gain insight from the perspectives of service members about what is needed to assist in effectively and successfully reintegrating into the workplace.

Research Questions

The primary research question (RQ) and subquestion for the study were as follows:

RQ: What are the lived experiences of Army Reservists or National Guardsmen with PTSD who served in Iraq or Afghanistan and are currently undergoing work reintegration issues?

Subquestion: What are service members' perspectives on aspects of the workplace environment that inhibit successful reintegration?

Theoretical and Conceptual Framework

I applied a social constructivist theoretical lens to examine participating service members' lived experiences. Social constructivists view the learner to be at the center of the meaning-making experience (Thomas, Menon, Boruff, Rodriguez, & Ahmed, 2014). Social constructivists believe that knowledge is constructed as learners make sense of their experience in the world within their social context (Thomas et al., 2014). Social constructivists actively engage learners in the learning process, thereby bringing their perspectives into the process (Thomas et al., 2014).

This study was a hermeneutic phenomenological study. Phenomenological researchers focus on the meaning of the experience (Cohen et al., 2000). Edmund Husserl is a central figure in phenomenological movement; his ideas evolved and changed over time (Cohen et al., 2000). Husserl's concepts involved phenomenological reduction, which he used to assign universal essence; this concept involved reducing particular facts to general essences (Cohen et al., 2000). Husserl used mathematical metaphor bracketing or the setting aside of biases, personal commitment, and understanding of the meaning of the experiences as they are being described (Cohen et al., 2000). Other concepts emerged from Husserl's work such as *life-world*, which is the

world of lived experiences and is part of Husserl's unpublished work (Cohen et al., 2000). Hermeneutics is the subjective experience of the participant told through the life world of their story; it is an interpretive process of the narrative description of the experience (Kafle, 2010).

I used hermeneutic phenomenology as the conceptual framework as it permitted the participating service members to discuss their lived experiences, bringing meaning and understanding to their experiences and providing deep, rich, thick data to add to existing knowledge (see Kalfe, 2011). This approach can empower participants as they disclose their experiences and perspectives (Cohen et al., 2000). With insight on the experiences and perspectives of service members, clinicians may be able to more effectively assist service members. Counselor educators also may be able to develop appropriate training necessary to assist service members successfully reintegrate in the workplace. The conceptual framework related to the RQs as the questions concerned the lived experiences of service members.

Nature of the Study

The nature of this research study was qualitative. According to Husserl (cited in Cohen et al., 2000), the intent of hermeneutic phenomenology is to gain understanding through interpretation of the meaning of the phenomenon of interest in its context. Husserl's concept of hermeneutic phenomenology has been expanded over the years and is widely used in nursing research (Cohen et al., 2000). Cohen et al.'s (2000) use of hermeneutic phenomenology appears to be influenced by Husserl's concepts of intentionality and consciousness as key components in conducting nursing research--

specifically, to understand patients' perception of their experience and how they give meaning to the experience. Intentionality is "directed towards something" (p. 11), and consciousness is an awareness of the world and is always intentional (Cohen, 2000). These two components aligned with this study as the goal was to bring an understanding of service members' experiences through their awareness to assist in developing best practices for students and clinicians in serving this population.

Cohen et al. (2000) sought to understand the patient's experiences of health, illness, and treatment; this concept was appropriate for this study as I sought to understand service members' experience of health, PTSD, and reintegration. Both studies focused on health and wellness and the experience during the illness and the outcome of that illness on the patient and the service member. According to Cohen and Crabtree (2008), qualitative research is used to study the behavior, perspectives, and experiences of individuals, groups, or cultures. Qualitative research is both interpretative and naturalistic (Cohen & Crabtree, 2008).

The interpretative component focused on bringing understanding of and meaning to the service members' experiences in the world in which they live (Cohen & Crabtree, 2008). The naturalistic component allowed the service members' observations and interviews to take place in their natural setting (Cohen & Crabtree, 2008). More specifically, hermeneutic phenomenology has evolved from the perspectives of merely learning about the lived experiences to the expansion of three basic ideas (Cohen et al., 2000). First is the existence of the service members; second, the investigation of how

things relate to the service members' existence; and third, the interpretation of the service members' existences (Cohen et al., 2000).

Sample

One of the components of hermeneutic phenomenology is intentionality; service members can express awareness of their experiences, not just their feelings and thoughts about the situation (Cohen et al., 2000). This aspect of hermeneutic phenomenology was appropriate for this study as many service members have shut off their emotions and exist in the realm of their personal experiences (Cohen et al., 2000). More specifically, hermeneutic phenomenology is language, as it conveys the experiences of individuals through writing and speaking, as well as how they engage in activities (Cohen et al., 2000). Language is an important aspect of this methodology as service members have a language and culture of their own (Cohen et al., 2000). The opportunity to capture that language through semistructured interviews with the participants added to the richness and depth of this study.

I used both purposive homogenous sampling and snowball sampling to recruit six participants for this study. Purposive sampling is relevant to qualitative research as its goal is to focus on particular characteristics of a population of interest (Laerd, 2012). Purposive homogenous sampling was the best choice for this study as I sought to explore the experience of particular individuals within an identified population (Laerd, 2012).

Snowball sampling is a nonprobability technique where participants in an existing study refer or recruit other participants among their friends or acquaintances (Laerd, 2017). Snowball sampling is used when the population of interest is difficult to find or

not easily accessible; due to the inclusionary criteria snowball sampling was used to recruit participants (Laerd, 2017). Participants included Army Reservists and National Guardsmen from the state of Alabama and the population for this study ranged in age from 30 to 59. The participants included both male and female service members from all ethnicities who met the inclusionary requirements and were willing to participate. The prerequisites for participation in this study included (a) service members who deployed to Iraq, Afghanistan, or both for 6 months or longer; (b) service members with a diagnosis of PTSD; (c) self-identified as currently experiencing problems with work reintegration; and (d) an Army Reservist or National Guardsman from Alabama. I recruited service members from local centers serving veterans. I utilized one 90-minute semistructured interview to gather data. Semistructured interviews allowed me to engage the participants in a formal manner while asking questions that I structured based on their relevance to the topic (Cohen & Crabtree, 2000; Rabionet, 2009). I recorded interviews to ensure accuracy.

According to Cohen and Crabtree (2008), the data gathered from the participants about their experience is considered reliable and comparable. All interviews were audio-recorded and stored in a secure folder on my password protected computer. All participants' information was also stored in my computer with an assigned identification code to ensure confidentiality.

This design allowed participants the ability to give a voice to their experiences and to do so in a safe environment. Moreover, it focused on gaining a greater understanding of the phenomenon under investigation (Cohen et al., 2000). Finally, this

study was not abstract, but the conscious experiences of service members and provided rich, thick, detailed data based on the intersubjective perspectives of the participants (Cohen et al., 2000). This research study can assist in the development of knowledge that could be used to train future counselors.

Operational Definitions

Operation Iraqi Freedom(OIF) and *Operation Enduring Freedom(OEF*): The official names of two campaigns of the U.S. military and its allies against Saddam Hussein (Armed Forces Health Surveillance Center, 2011).

Posttraumatic stress disorder (PTSD): A trauma- and stress-related disorder, according to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) (*DSM-5*, American Psychiatric Association [APA], 2013). Clinicians focus on four clusters when diagnosing PTSD: reexperiencing, avoidance, negative cognitions and mood, and arousal (APA, 2013). The first cluster occurs when the service member continues to experience the trauma repeatedly; the experience may represent memories, dreams, or flashbacks of the traumatic event (APA, 2013). The second cluster occurs as the service member tries to forget everything relating to the event and disengages from activities, experiences, and cues that are reminders of the event (APA, 2013). The third cluster occurs when the service member is unable to process information accurately because of his or her distorted perception of the cause of the event, which often leads to the service member withdrawing from activities (APA, 2013). The fourth cluster occurs when the service member engages in risky and self-destructive behavior, resulting in the service member being on guard all of the time and experiencing difficulty sleeping (APA, 2013).

These clusters represent distinct categories of symptoms that characterize PTSD. A person diagnosed with PTSD must present with one or two (depending on the cluster) symptoms from each cluster (APA, 2013).

Reintegration: A stage of the deployment cycle (predeployment, deployment, postdeployment, or reintegration), as defined by the National Council on Family Relations (2014). Service members demonstrate reintegration as they function independently while reentering their daily living routines before deployment which includes family and friends, work and school, and personal experiences (Marek et al., 2014; Rensik et al., 2014).

Veteran/Service member: An individual who has served on active duty in the Armed Forces, Military Reserves, or Coast Guard (U.S. Census Bureau,2014). Individuals who are National Guard or Reserve are considered veterans if they have served in active duty status, which does not include summer camp and the initial training session (U.S. Census Bureau, 2014).

Assumptions

My exploration of literature regarding service members with PTSD who were experiencing work reintegration challenge along with my personal opinion on the subject resulted in some assumptions. I assumed quantitative research would not be the best type of study to gain understanding and meaning as supported by the literature. According to Cohen and Khan (2000), hermeneutic phenomenology focuses on bringing meaning and understanding through the examination of the lived experiences of the participants. I

assumed a qualitative study was best to explore the experiences of service members to gain a better understanding of the barriers that impedes successful employment reintegration.

I assumed that the service members participating in this research study would present information truthfully and accurately. I assumed that the information disclosed by the service members would be relevant to the RQs. I assumed that service members would be willing to participate in a research study that may help future service members with employment reintegration. I assumed the commonalities among this homogenous group would reveal similarities. There is a need for programs that promote successful employment reintegration among service members (Resnik et al., 2012). I assumed this research study could influence further studies that can be used to show generalizability regarding successful employment reintegration.

Scope and Delimitations

I described the experiences of Alabama Army Reservists and National Guardsmen with PTSD who were experiencing work reintegration challenges. This population directly aligned with my RQs as I investigated the lived experiences and perceptions of service members to gain a better understanding of their experiences. Hermeneutic phenomenology asks questions about an individual's experiences and how they interpret those experiences (Cohen & Khan, 2000).

I used a social constructivist theoretical lens to explore lived experiences of service members with PTSD who were experiencing work reintegration challenges. According to Vygotsky (1934), social constructivist theory emphasized the role of

language and culture as important in how people perceive the world. Hermeneutic phenomenology and social constructivism paired together were the best approach and theoretical lens to derive knowledge from and construct conclusions about the meaning of service members' experiences that can add to the body of knowledge regarding best practices for population. According to Creswell (2009), meaning is not always a process that individuals come to on their own, but sometimes through interaction with others; I hope that the service members in this study derived some meaning from their experiences as a result of the interview process and through sharing their stories.

The delimitations of this study were only participants who were in the Army Reserve or National Guard were allowed to participate. Studies have been done on other branches of the military but not on Army Reservists or National Guardsmen. Another factor was no full-time military service members were allowed; active duty service members have support and access to mental health care that Army Reservists and National Guardsmen do not. Geographical location was limited to Alabama.

Limitations

Due to the small sample and its subjectivity, this study cannot be generalized to other branches of the military (Creswell, 2009). The findings of this hermeneutic phenomenological study were not able to be applied to other military branches; however, they can be used as a foundation to influence other studies that can contribute to knowledge through understanding and meaning. An awareness of my sample, as well as the manner in which the questions were presented, answered, interpreted, and reported,

could contribute to researcher bias (Creswell, 2013). I used member checking and rich, thick data to ensure that researcher bias did not occur.

Significance

Service members with PTSD who served in Iraq and Afghanistan face physical, mental, familial, and social challenges as they return home (Wehman et al., 2009). PTSD is a debilitating disorder that affects 8% of all adults in the US and up to 60% of selected military service members (Murdoch et al., 2011). According to Murdoch et al. (2011), service members with PTSD have high rates of depression, suicide attempts, and problems with substance use. Approximately 1.5 million service members currently have clinical diagnoses of PTSD (Murdoch et al., 2011). Thousands of service members with PTSD have filed for disability benefits (Murdoch et al., 2011). Due to a lack of evidence linking the service members' PTSD to the military, many service members who need VA benefits are not receiving them (Murdoch et al., 2011). Those who receive benefits can access mental health services, medication, housing, training, and support services (Murdoch et al., 2001). The recipients of PTSD benefits report a reduction in symptoms (Murdoch et al., 2011).

As many as 96% of service members express needing help to readjust to civilian life (Sayer et al., 2010). An important aspect of civilian life is the ability to obtain and maintain employment; PTSD directly affects service members' employability (Murdoch, et al., 2011). PTSD can affect the service members' ability to concentrate on job tasks and affect the service members' ability to work with some coworkers (Murdoch, et al., 2011). Service members experience certain events in the workplace environment such as

loud sounds and sudden movements that might trigger flashbacks (Murdoch, et al., 2011). PTSD has a significant impact on the quality-of-life for service members as they experience challenges with homelessness and unemployment (Murdoch et al., 2011; Sayer et al., 2010; Schnurr, Lunney, Bovin, & Marx 2009; Wehman et al., 2009). A better understanding of the identified barriers and perceptions of service members with PTSD who face employment reintegration challenges through their lived experiences can help develop counselor educators with the necessary skills to assist these service members in regaining their sense of purpose through employment.

Social Change

The Iraq War has altered the lives of many service members and their families forever (Resnik et al., 2012). Many groups and individuals experience marginalization due to an inability to access programs and service needed to lead healthy and productive lifestyles. Service members who deployed to The Iraq War experience marginalization as they encounter a variety of issues from mental health, family and parenting, marital and partner relationships, homelessness, and financial and employment issues because they are unable to access the necessary services (Resnik et al., 2012). One of the implications of social change is to bring awareness to counseling professionals, counselor educators, and policy makers about the challenges service members are encountering. More specifically, this research could help lay a foundation to develop training for future counselors that can be generalized to work with the growing population of service members with PTSD who are experiencing employment reintegration issues. These counselors could serve as agents of social change as they promote a better quality of life

for these service members through a better understanding of the obstacles they face with work reintegration.

Summary

In Chapter 1, I introduced this study and identified the problem of service members with PTSD who are experiencing work reintegration challenges. I provided background information; stated the research problem, purpose, and RQs; and discussed the conceptual framework, nature, and significance of the study. I also discussed the assumptions, scope and delimitations, and limitations in Chapter 1. In Chapter 2, I will review relevant articles that illuminate the study phenomenon, service members with PTSD who face employment reintegration challenges.

Chapter 2: Literature Review

In this study, I explored the challenges of service members with PTSD regarding employment reintegration. PTSD is prevalent among service members who have been deployed to Afghanistan and Iraq and is known as one of the signature injuries of this war (Burke et al., 2009). Reintegrating from the military to a civilian workplace can be difficult for service members with mental health issues, especially those with PTSD (Til et al., 2013). For example, in one study higher rates of reported PTSD symptoms were associated with a self-reported increase in alcohol use after returning from deployment from Afghanistan and Iraq (Burnett-Zeigler et al., 2011). Researchers have consistently described reintegration as a difficult process (Ahern et al., 2015; Burnett-Zeigler et al., 2011; Elnitsky, Fisher, & Blevins 2017). Approximately one-half of the service members involved in OIF and OEF perceived that they had difficulty with reintegration; within this group of veterans, binge drinking and PTSD were prevalent (Sayer et al., 2015). One of the primary problems experienced by service members after returning home is feeling disconnected from the people at home including family and friends who have not experienced what the service members have (Ahern et al., 2015).

The purpose of this study was to gain an understanding of the lived experiences of service members with PTSD who were experiencing challenges reintegrating into the workplace. As more service members return home from OEF/OIF, they are being diagnosed with psychological problems earlier when compared to other service members. Yet, little is known about their ability to function at home, in society, and in the workplace (Sayer et al., 2010). Thirty-eight percent of service members deployed to

OEF/OIF had higher rates of interpersonal conflict, PTSD, depression, and overall mental health issues after deployment (Burnett-Zeigler et al., 2011). Among these service members, 42% of National Guard and Army Reservists experienced the aforementioned issues, as opposed to 20% active duty service members (Burnett-Zeigler et al., 2011). The stigma associated with mental health and veterans' inability to reintegrate has made the process difficult for them in the community and the workplace (Collinge, Khan, & Soltysik, 2012). The RQ that framed this study was, What are the lived experiences of Army Reservists and National Guardsmen with PTSD who served in Iraq or Afghanistan and who are currently undergoing work reintegration issues?

In this chapter, I provide an overview of recent literature on veterans with PTSD reintegrating into the workplace after being deployed to Iraq or Afghanistan or both. After being involved in the longest war in the history of the United States, service members have returned home to an array of challenges in their lives regarding reintegrating into their communities, families, and school and work life. In Chapter 2, I review the historical and current literature related to service members with PTSD who are experiencing work reintegration challenges. Before reviewing the literature, I provide an overview of the literature search strategy and the theoretical foundation and conceptual framework of the study. I begin by discussing the diagnosis, symptoms, and history of PTSD and the factors that contribute to PTSD--for example, deployment and exposure to combat, occupation, and gender. I also explore the stigma associated with PTSD and co-occurring mental health issues such as depression, TBI, and substance use disorder.

Reintegration into community, family, and work spheres is also discussed as is the impact of PTSD on reintegration. Chapter 2 concludes with a summary and conclusion.

Literature Search Strategy

I searched databases including PyscINFO, ProQuest Central, and ProQuest Nursing and Allied Health , Sage, and Taylor and Francis via the Walden University Library. I extended my search to include the *Journal of Rehabilitation and Research Development* and *Military Medicine*, both of which I accessed in Google Scholar. The articles ranged from 2009 to the present. The keywords in the search were *service members*, *veterans*, *reservist*, *shell shocked*, *post-traumatic stress disorder*, *signature injury*, *mental health disorder*, *reintegration*, *adjustment*, *work*, *employment*, *workforce*, *workplace*, *Iraq*, and *Afghanistan*.

Theoretical Framework

The theory that I used to better understand my data was social constructivist theory. Social constructivist theory stems from sociology with principles regarding how individuals learn (Thomas et al., 2014). There are three social constructivist principles regarding learning: First, learning is a result of a person's exchange with the environment; second, the conflict that occurs when a person has two conflicting thoughts at the same time serves as a catalyst for learning; and third, the social environment plays a vital role in the construction of knowledge (Thomas et al., 2014).

Lev Vygotsky developed social constructivist theory based on his beliefs that social interaction is essential to the development of cognition and that community plays a role in making meaning (as cited in McLeod, 2014). This theory operates on the premise

that learning cannot be separated from its social context and that human beings construct their knowledge by being active participants in the process (Vygotsky, 1934). Social constructivist theory can be useful in understanding why and how individuals incorporate and use new knowledge, which influences behavior change (Thomas et al., 2014). Social constructivist theory can also be useful in the dissemination and sharing of information (Thomas et al., 2014). Vygotsky highlighted the importance of language and culture in cognitive development and how people perceive their world; language and culture provide a framework that allows people to experience, communicate, and understand reality (as cited in University College Dublin, 2017). People learn through personal significance and meaning not just through colors and shapes of what they see but what makes sense and has meaning to them (as cited in University College Dublin, 2017, p. 39).

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According to Vygotsky (1978), *good learning* occurs in the zone of proximal development (ZPD), which he distinguished from the individual's actual and potential levels of development. Vygotsky defined the ZPD as "the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem-solving under adult guidance, or in collaboration with more capable peers" (p. 86). According to Puntambekar and Hubscher (2005), the ZPD is the amount of learning possible by a student given the proper instructional conditions. There is consistency regarding the ZPD in both Puntambekar and Hubscher's and Vygotsky's perspectives on the use of interaction between a teacher and learner and the amount of learning that is possible when you have the right instruction.

According to Cole (2001), the word *proximal* indicates that closely assisting a person in learning increased their competence enhancing and building on their existing abilities. Proximal assistance is multifaceted. According to Thomas et al. (2014), there are three factors involved in the guidance and assistance process. Cole (2001) agreed that Vygotsky's (1934) concept of learning builds upon current knowledge. First, intersubjectivity is the process where two people begin with a different understanding and come to a common understanding, creating this common understanding as they adjust

their perspectives of the other. Second, scaffolding is the social and instructional support given by the teacher to the student for learning new concepts. Third, guided participation occurs when a mentor or teacher is paired with the student to practice and engage in a cultural activity.

Hermeneutic phenomenology is how people go about understanding the world in which they live (Cohen et al., 2000). The use of hermeneutic phenomenology as the conceptual framework and social constructivist theory as theoretical framework complement one another as they both seek to bring understanding and meaning about the phenomenon under investigation to individuals about the world in which they live (Thomas et al., 2014; University College Dublin, 2017).

Hermeneutic phenomenology as the conceptual framework and social constructivist theory as the theoretical orientation, paired together for this research study, allowed me to explore the lived experiences and perspectives of service members with PTSD who face employment reintegration challenges. The conceptual framework and theoretical orientation that I chose further allowed me to identify barriers that impede service members' successful reintegration into the civilian workplace after deployment to Afghanistan and Iraq.

I used social constructivist theory to develop meaning and understanding through interplay, which is an important aspect of this theory (Adam, 2017). Interplay occurs between the teacher, the student, and the task or, in this study, between me as the researcher, the service member, and the meaning and understanding gained through the

interviewing process. I asked questions that allowed me to engage and interact with the service members about the experiences they brought to the interview.

The literature I examined in the following sections includes a synthesis of concepts that are associated with service members and PTSD, the stigma associated with PTSD, factors that contribute to PTSD, reintegration issues among service members deployed to Afghanistan and Iraq, the impact of PTSD on reintegration, and the impact of PTSD on employment reintegration in the civilian workplace.

Literature Review Related to Key Variables and/or Concepts

Posttraumatic Stress Disorder and Diagnoses

PTSD as an outcome of war is not new. During World War I, PTSD was referred to as shell shock. The symptoms associated with shell shock were amnesia; headache; dizziness; an inability to reason; inability to sleep, walk, or talk; extreme fear; hypervigilance; irritability; inability to concentrate; and feelings of helplessness (Jones, Fear, & Wessely, 2007; Loughran, 2010). It was known as the signature injury of WWI (Jones et al., 2007; Loughran, 2010). In World War II, PTSD was known as combat stress reaction, which was a response to trauma warfare and bombardment (Loughran, 2010).

Still known today as one of the signature injuries of war, PTSD has encompassed a broader range of symptoms and criteria (Burke et al, 2009). PTSD is a mental health disorder that must meet certain criteria set forth in the *DSM-5* (APA, 2013). Currently, the *DSM-5* defines PTSD as exposure to actual or threatened death, serious injury, or sexual violation (APA, 2013). The exposure must result in one of four ways: direct

experience to the traumatic event, witnessing the traumatic event, learning of a traumatic event that has occurred to a close family member or close friend that actually threatened death or violence, or experiencing first-hand repeated or extreme exposure to the traumatic details of the event (APA, 2013).

The criteria for PTSD focus on behavioral symptoms and examine four specific clusters of behavioral responses: reexperiencing, avoidance, negative cognitions and mood, and arousal (APA, 2013). Reexperiencing encompasses recurrent dreams, flashbacks, spontaneous memories, or intense or prolonged psychological distress (APA, 2013). Avoidance refers to distressing memories, thoughts, feeling or reminders, or triggers of the traumatic event (APA, 2013). Cognition and mood deal with feelings that include the distorted and persistent sense of blame, along with a loss of interest in activities, and an inability to remember specific aspects of the event (APA, 2013). Finally, arousal is marked by aggressive, reckless, or self-destructive behavior; sleep disturbances; hypervigilance; or related problems (APA, 2013).

Symptoms of PTSD. Individuals with PTSD exhibit various symptoms such as flashbacks, nightmares, inability to sleep, difficulty concentrating, and being easily startled (APA, 2013). Approximately 30% of service members who returned from Iraq reported sleep disturbances even 3 to 4 months after they arrived home; among those who sustained head injuries, the rates were as high as 53% (Capaldi, Guerrero, & Killgore, 2011). Individuals with PTSD are easily angered and irritated, and many times engage in self-destructive behavior (APA, 2013). Anger frequently co-occurs with PTSD, but it has also impacted half of service members who do not have a diagnosis (Worthen & Ahern,

2014). Individuals with PTSD will often avoid people, certain places, and situations that remind them of trauma (APA, 2013).

Symptoms and gender. In diagnosing PTSD, various assessments are used. There is a difference in the cluster rates due to gender; it is unclear if these differences are real or due to the assessment used (Murphy, Elklit, Chen, Ghazali, & Shevlin, 2018). In a study conducted by Haskell et al. (2010), the literature revealed gender difference existed in the screenings for military sexual trauma (MST), depression, obesity, and PTSD (Haskell et al., 2010).

Females showed higher rates with intrusive thoughts, distressing dreams, flashbacks, avoidance of reminders, negative emotional state, diminished interest, exaggerated startle response, and sleep disturbance, whereas males reported significantly higher rates of reckless or self-destructive behavior (Murphy et al., 2018). There were some inconsistencies regarding the number of PTSD cases due to gender. In a study conducted by Crum-Cianflone and Jacobson (2014), while females had higher rates of postdeployment PTSD, there was a lack of consensus regarding the detection of differences by gender and PTSD among the seven studies involved. It is important to use the same type of assessment and same time frame when assessing male and female service members for PTSD upon their return from deployment in Afghanistan and Iraq.

History of PTSD. The term *shell shocked* was first introduced during World War I (WWI) (Crocq & Crocq, 2000). WWI was the first war fought with massive industrial means which coincided with the scientific development of psychiatric diagnostic techniques as we know them today (Crocq & Crocq, 2000). The number of psychiatric

cases was greater than expected; it began with four cases of "battle hypnosis" following the military action (Crocq & Crocq, 2000). In December of 1914, the number of service members presenting with mental health issues was overwhelming due to the artillery battle (Crocq & Crocq, 2000). Initially, all service members were housed together in one hospital but soon a psychiatric hospital was needed to care for a large number of soldiers who were suffering from fright and anxiety due to an explosion of enemy shells and mines and seeing the maimed or dead bodies of comrades (Crocq & Crocq, 2000).

The symptoms they exhibited were sudden muteness, deafness, tremors, inability to stand or walk, episodes of losing consciousness, and convulsions (Crocq & Crocq, 2000). Shell shock was the name given to soldiers suffering from mental disorders due to combat stress (Crocq & Crocq, 2000). In 1915, *The Lancet* medical journal presented the cases of three soldiers all exhibiting the same symptoms of memory loss, vision, smell, and taste; each soldier had been shocked by the shells exploding (Crocq & Crocq, 2000).

World War II (WWII) was marked by contributions to the study of psychiatry by American psychiatrists (Crocq & Crocq, 2000). Soldiers with mental health issues were sent back to the base hospital and only 5% were returned to duty (Crocq & Crocq, 2000). The term *exhaustion* was used to describe combat psychiatric cases; the number of psychiatric cases was overwhelming (Crocq & Crocq, 2000). Of all the overseas armed forces, 86 per 1000 soldiers each year were admitted to hospitals; the neuropsychiatric rate was 43 per 1000 per year (Crocq & Crocq, 2000). During WWII, many studies were conducted examining soldiers who had been affected with psychiatric disorders (Crocq & Crocq, 2000). Germany was intolerant of long-lasting psychiatric disorder and felt it best

to eliminate the weak or degenerated instead of letting them infect the entire community (Crocq & Crocq, 2000). The soldiers were given some form of psychological assistance and then sent back to the first aid station to rest, eat chocolate, and drink milk (Crocq & Crocq, 2000). Moscow showed the existence of specific diagnostic labels to classify PTSD; they referred to it as *affective shock reactions.* They characterized it by acute and sub-chronic symptoms; the reaction they observed after an earthquake, train accident, or wartime events (Crocq & Crocq, 2000).

During the Vietnam war, treating psychiatric disorders in the forward areas was successfully applied; the forward areas were away from the frontlines where the noise and action could still be heard and witnessed (Crocq & Crocq, 2000). It was estimated that 700,000 Vietnam veterans, almost one-quarter of all soldiers sent to Vietnam, needed some form of psychological assistance (Crocq & Crocq, 2000). The prevalence and the severity of PTSD were astounding; the increasing number of diagnosed cases led to the adoption of a PTSD diagnostic category in 1980 in *DSM-3* (Crocq & Crocq, 2000). During the evolution of PTSD, various terms have been used to identify the mental health issue, including those mentioned in the book *Men Under Stress* which gave a description of 65 clinical cases referred for PTSD as reaction to combat, war neuroses, and operational fatigue (Crocq & Crocq, 2000).

Factors That Contribute to Posttraumatic Stress Disorder

The Center for PTSD (2018) reported that the wars in Afghanistan and Iraq were the longest wars since Vietnam; as a result, there were many stressors, situations,

illnesses, and obstacles service members experienced that contributed to the development of PTSD (Center for PTSD, 2018; McDevitt-Monahan, & Williams, 2014).

Deployment and exposure to combat. According to Lancaster, Cobb, Lee, and Telch (2014), service members were four to five times more likely to develop PTSD due to deployment; there are psychological stress symptoms related to deployment and the anticipation. The duration of this war required multiple deployments by some service members; many were deployed for up to five tours of duty (Armed Forces Health Surveillance Center, 2011). Exposure to combat and multiple tours of duty to a combat environment have the potential to cause physical and psychological injury to military personnel (McDevitt-Murphy et al., 2014). The stressors they faced were exposure to explosive devices (IEDs), ambush or attack from enemy combatants, small firearms, witnessing the loss of human life and injury to others, and always on the alert and are factors that are directly associated with the development of PTSD (McDevitt-Murphy et al., 2014). Life in a war zone often involves other forms of trauma in addition to combat-related violence. Ten percent of women and 1% of men reported being sexually assaulted during their time of deployment; sexual assaults in the military increase during war time (McDevitt-Murphy et al., 2014). In addition to the aforementioned deployment and combat exposure stressors, Huang and Kashwbeck-West (2015) found two additional factors. They found a perceived threat in the war zone to exposure to nuclear, biological, chemical weapons missiles, and incidents of friendly fire (Huang & Kashwbeck-West, 2015). Last, they identified guilt regarding the need to be forgiven for their role in hurting combatants and civilians (Huang & Kashwbeck-West, 2015). The largest

percentage of PTSD cases among male and female veterans occurred during the second through fourth deployment (Armed Forces Health Surveillance Center, 2011). The length of deployment is associated with the development of PTSD; the chance of developing PTSD increased by 2.2% for those deployed over 180 days (Shen, Arkes, & Pilgrim, 2009).

Occupation and PTSD. In 2013, Mayo, MacGregor, Dougherty, and Galarneau conducted a study to see whether various occupations in the military had an effect on new-onset PTSD and depression among service members. This study involved Navy and Marine Corps healthcare personnel, Marine Corps combat specialists, and Marine Corps and Navy service and supply personnel (Mayo et al., 2013). The healthcare specialists cared for the wounded before, during, and sometimes after injury and battle; the combat specialists performed actual combat; and the supply personnel performed logistics for the battle which put them at risk from the enemy as they traveled to set up stations and equipment (Mayo et al., 2013). The Navy health care and supply personnel reported more cases of PTSD than the Marines who were exposed directly to combat; however, the Marines were trained for battle and the Navy healthcare and supply personnel were not (Mayo et al., 2013). This study concluded that there was a definite association between military occupation and the development of PTSD (Mayo et al., 2013). Service members working directly with infantry, armor, and artillery reported the largest percentages of PTSD cases after the second and third deployment (Armed Forces Health Surveillance Center, 2011).

Life in a war zone entails various occupational specialties such as medical personnel and mortuary workers who report additional risk of exposure to extreme stress (McDevitt-Murphy et al., 2014). As medical personnel perform their duties, they are exposed to life-threatening activities and gruesome injuries in that war zone (McDevitt-Murphy et al., 2014). Mortuary workers from Operation Desert Storm, which was the Gulf War, were exposed to human remains that carried long-term negative psychological effects on their ability to readjust and the development of PTSD (McDevitt-Murphy et al., 2014). Veterans involved in previous wars reported the atrocities they were involved in with torture, war crimes, and mutilation of corpses added to the stressors they experienced (McDevitt-Murphy et al., 2014). Combat and non-combat veterans faced training accidents or completion of routine duty accidents such as falls and motor vehicle accidents (McDevitt-Murphy et al., 2014). Non-combat and non-medical service members' development of PTSD occurred after the second through the fourth deployment (Armed Forces Health Surveillance Center, 2011).

Gender and PTSD. Prior to 2013, women were not allowed in combat or any level below brigade, but women reported more combat-related events (Crum-Cianflone, & Jacobson, 2013). In the war in Iraq and Afghanistan, there was a sizable number of women who encountered combat situations; the number of commissioned officers and number of female reservists and guardsmen increased (Crum-Cianflone & Jacobson, 2013). Crum-Cianflone and Jacobson (2013) wanted to know if gender played a role in the development of PTSD among service members deployed to Iraq and Afghanistan.

Women service members were involved in combat events such as the handling of human remains, firefighting, and shooting of the enemy (Crum-Cianflone & Jacobson, 2013). Of the 18 studies examined in this comprehensive review, 7 found that there were no differences based on gender (Crum-Cianflone & Jacobson, 2013). The other studies raised questions regarding women being more vulnerable due to childhood sexual abuse and intimate partner violence, sexual abuse while serving, and, among women in the general population and military, women have a higher baseline rate of PTSD (Crum-Cianflone & Jacobson, 2013). Women appeared to have a higher risk for postdeployment PTSD although no real consensus was established (Crum-Cianflone & Jacobson, 2013). This study was limited due to a lack of deployment experiences among women and predeployment factors were not measured to see whether gender really made a difference for potential PTSD (Crum-Cianflone & Jacobson, 2013).

The challenges faced by female veterans are often overshadowed by male veterans; while female veterans face challenges with PTSD and how it affects their families, parenting, social lives, and work lives, little has been done to research the effects due to a number of male versus female veterans with problems as they return home (Mattocks et al., 2012). Women deployed to OIF/OEF experienced an enormous amount of stress both during the war and upon returning home (Mattocks et al., 2012). The lifetime prevalence of PTSD among US adult women is 9.7; more than one in eight women veterans screen positive for PTSD (Washington, Davis, Der-Martirosian, &Yano, 2013). The majority of women veterans use healthcare providers outside of the VA system who may be unaware of their veteran status and the risk of PTSD (Washington et

al., 2013). PTSD in women veterans has been associated with higher rates of reproductive and substance use disorders and other general medical issues (Washington et al., 2013).

Haskell et al. (2010) examined 1,032 male and 197 female veterans to better understand gender differences in the healthcare needed among recently returned veterans regarding the prevalence of depression, PTSD, military sexual trauma (MST), obesity, and chronic pain. Female veterans screened positive at higher rates for MST (14% vs. 1%) and for depression (48% vs. 39%) than male veterans but were less likely to screen positive for PTSD (21% vs. 33%) (Haskell et al., 2010). Men screened higher for obesity (Haskell et al., 2010). The finding of this study directly conflicted with Crum-Cianflone and Jacobson's (2013) study regarding women developing PTSD at a higher rate than men. Crum-Cianflone and Jacobson were not able to determine if the higher rates of PTSD were due to lower rate of combat exposure or other traumatic events in their lives such as childhood sexual assaults and intimate partner violence which might have increased their vulnerability for PTSD.

Quality of life and PTSD. A longitudinal study was conducted to see if there was an association between PTSD and subjective quality of life (SQOL) (Giacco, Matanov, & Priebe, 2013). The study explored how changes in the levels of PTSD symptomatic clusters of intrusion, avoidance, and hyperarousal were associated with changes in SQOL (Giacco et al., 2013). Individuals with war-related PTSD had a high level of hyperarosual which was associated with lower levels of SQOL. The Manchester Short Assessment of Quality of Life (MANSA) was used to assess the individuals' subjective quality of life.

The domains assessed were employment, financial situation, friendships, leisure activities, accommodations, personal safety, living situations, sex life, relationship with family, physical health, and mental health based on a scale of 1-7 (Giacco et al., 2013). This study found that a reduction in hyperarosual may improve the SQOL and improvement in the SQOL would lead to a reduction in hyperarousal symptoms (Giacco et al., 2013). The strength of this study was the use of participants who were affected by war; the limitation was the use of refugees (Giacco et al., 2013).

In a study conducted by Vogt et al. (2016) to examine the quality of life of males and females who served in Iraq and Afghanistan, PTSD was not associated with work or relationship status, but it did indicate poorer work performance and family satisfaction among these men and women. PTSD had an adverse effect in various areas in the lives of men and women who served in Iraq and Afghanistan (Vogt et al., 2016). Impairment was found in the individuals' ability to function as a parent, spouse or partner, and as an employee (Vogt et al., 2016). Post-9/11 veterans had more difficulty in securing jobs than their civilian peers; women veterans who served in Iraq and Afghanistan were more likely to be unemployed and divorced (Vogt et al., 2016). Depression and alcohol were often associated with PTSD and it also led to job dissatisfaction (Vogt et al., 2016).

Schnurr and Lunney (2016) conducted a study to examine symptom benchmarks of improved quality of life in female veterans with PTSD. Four domains were examined: response, no response, loss of diagnosis, and remission (Schnurr & Lunney, 2016). Response was sought to all measures which were social and occupational functioning measures assessed with the Clinicians Administered Post-Traumatic Scale (CAPS)

(Schnurr & Lunney, 2016). The health-related quality of life measures was assessed with Role-Emotional, Role-Physical, and Social Functioning scales (Schnurr & Lunney, 2016). The life satisfaction measures were assessed using the Quality of Life Inventory (QOLI) (Schnurr & Lunney, 2016). There was only one good endpoint with response (Schnurr & Lunney, 2016). Loss of diagnosis was associated with improvement on all measures except the self-rated social functioning and with achieving a good endpoint on all measures (Schnurr & Lunney, 2016). Remission was associated with improvement in clinician-rated social impairment and a good endpoint in clinician-rated occupational impairment (Schnurr & Lunney, 2016). In this study, Schnurr and Lunney focused on scales that measured clinician significant improvement followed by the conceptualization of real-life impact rather than just symptoms. Two interventions were used in this study: Prolonged Exposure (PE) and Present-Centered Therapy (PCT). Prolonged Exposure is a treatment used with anxiety and PTSD disorders where the patient is intentionally confronted with the fear within a safe environment with the goal of reducing the fear and negative reactions to the same stimuli (Foa, 2011). PE treatment in this study included education about common reactions to trauma, breathing retraining, prolonged recounting of trauma memories during sessions, homework listening to a recording of the recounting of the trauma, and discussion of thoughts and feelings related to exposure exercises (Schnurr & Lunney, 2016). PCT specifically utilized the group process, psychoeducation, and cognitive behavioral therapy in the study. Psychoeducation was used in the first two sessions and thereafter focused on identifying, discussing, and reviewing general daily difficulties in a supportive, non-directional manner (Frost, Laska,

& Wampold, 2014). Last, a study was conducted by Nachar, Guay, Beaulieu-Prevost, and Marchand (2012) to assess if psychosocial predictors and PTSD affected the health quality of life. In this study, 94 participants were screened concerning social supports, coping skills, and PTSD symptoms. All three variables were considered predictors of the impact one's health plays on the quality of life (Nachar et al., 2012). Quality of life was measured by various assessments. Various factors were assessed, such as occupation and financial status, personal relationships, social issues, health issues, and coping skills, to provide a comprehensive view of the service members' quality of life upon return.

Stigma Associated With PTSD

A stigma has been associated with mental illness in the civilian world for many years and has been the reason many individuals do not seek treatment. The literature that I reviewed revealed a consensus among service members regarding reluctance to seek treatment due to the stigma associated with mental illness (Mittel et.al., 2013; Steenkamp, Boasso, Nash, & Litz, 2014; Sudom, Zamorski, & Garber, 2012). My research also indicated consensus regarding the assumptions among the public that individuals with mental illness are dangerous and are not entitled to full access to health care, housing, education, employment, and accessibility to resources (Mittal et al., 2013; Sudom et al., 2012).

A study conducted by Sudom et al. (2012) regarding stigma and barriers to mental health care, examined the Canadian military to see the impact of common mental health disorders such as depression, PTSD, and social phobia among the military (Sudom et al., 2012). These disorders resulted in a number of negative outcomes to the military as an

employer, including productivity, absenteeism, and turnover (Sudom et al., 2012). A stigma is associated with mental illness and PTSD is no different; what is different is what is associated with that stigma (Mittal et al, 2013; Steenkamp et al., 2014; Sudom et al., 2012).

The stigma in this study was associated with practical concerns about seeking treatment such as difficulty getting an appointment and how to get to that appointment (Sudom et al., 2012). There was also stigma associated among those seeking treatment who believed that the treatment was ineffective, therefore it was less likely to be sought by the service member (Sudom et al., 2012). The measures used in this study were care-seeking propensity to determine if there was interest in receiving treatment for stress; emotional, alcohol, or family problems; use of mental health services to determine if counseling was used during deployment; and location of deployment to determine if the mental health problems were handled by primary care or transferred to Kandahar Airfield for specialty care (Sudom et al., 2012). The findings of this study were mixed and indicated that the stigma of care might be driven by the underlying mental illness of the service member and that the social stigma, in part, is the service member's devalued self-image that is projected onto others (Sudom et al., 2012). This study also indicated that further investigation regarding barriers to health care is needed (Sudom et al., 2012).

A study conducted to examine the association of stigma of PTSD among veterans revealed stigmatizing mental illness can result in discriminating activities by people in power such as employers and landlords (Mittal et al., 2013). Researchers have shown that individuals with mental illness have lost opportunities for housing and work,

received poorer quality primary health care, and were less likely to receive fair treatment in the criminal justice system (Mittal et al., 2013). Over the past 2 decades, efforts to dispel the stigma and myths were still met with social avoidance and assumptions about the person being dangerous (Mittal et al., 2013).

Public opinion, coupled with self-stigmatizing, produced low self-esteem and reduced quality of life; it was also associated with non-compliance with treatment which impeded employment, independent living, and opportunities for a full social life for service members (Mittal et al., 2013). Five themes emerged from this study: stereotype awareness stigmatizing labels for PTSD, which included "crazy, violent, non-social, weird, cold-hearted, unfit to raise children, weak, shell-shocked, robot, unreliable, on guard, unstable, and pissed off at the world"(Mittal et al., 2013, p. 88); reactions to stigmatizing stereotypes which included agreeing or disagreeing with the opinions of the public in regards to the behavior of service members with PTSD; support from peers in this area service members believed they are understood by other veterans who have similar experiences; treatment avoidance service members are reluctant to seek treatment due to crazy labels for fear of being institutionalized; and the last theme is different from other mental disorders which views PTSD as less stigmatizing than schizophrenia and other disorders which are biological or hereditary whereas, PTSD has many causes. (Mittal et al., 2013).

In a study conducted to examine mental health stigma across deployment cycle, Marines were assessed 1 month prior to a 7-month deployment to Afghanistan and again at 1-, 5-, and 8-month intervals upon return (Steenkamp et al., 2014). They examined

three predictors of the course of stigma: PTSD severity, vertical and horizontal unit cohesion, and mental health treatment while deployed (Steepnkamp et al., 2014). The perception of mental health stigma was assessed with the Barriers to Care 6-item scale measuring the severity of the symptoms; vertical cohesion with leadership was assessed with the 12-item Company and Squad/Platoon Perception Questionnaire; horizontal cohesion was assessed with a scale developed by Podskoff and MacKenzie with a 1 to 5 response rating; and mental health treatment was assessed by the Naval Center for Combat Operational Stress Control (Steepnkamp et al., 2014). These researchers found that perceived stigma was low and stable over time. The stigma of mental illness, be it real or perceived, has been and continues to be a barrier to treatment. Mental health stigma is a community problem, not just the individual's problem; the stigma associated with mental health, due to military service or not, must be addressed to create a healthier society for all.

PTSD and Co-occurring Mental Health and Neurological Issues

The Iraq War has produced a new generation of service members who are at risk for developing serious mental health issues (Brown, Williams, Bray, & Hourani, 2012). More than 2 million U.S. military combat service members have participated in the war (Ursano et al., 2016). Over 1 million have been diagnosed with one or more mental health issues (Ursano et al., 2016.

Depression. Multiple studies have been conducted on service members returning from deployment; in these studies, there are some commonalities with regard to PTSD and depression, with alcohol use disorder being closely associated (Brown et al., 2012;

Mustillo et al., 2015; Norman, Hamblen, Hallet, Southwick, & Pietrzak, 2018). Mustillo et al. (2015) conducted an overview of three mental health issues, depression, PTSD and alcohol misuse, among active duty service members returning home from Iraq and Afghanistan. The researchers found that 18% of the service members returning from Iraq and Afghanistan met the criteria for PTSD (Mustillo et al., 2015). They found that just being deployed to Iraq and Afghanistan significantly increased the service member's potential to develop PTSD as did having been deployed over 180 days and multiple deployment tours (Mustillo et al., 2015).

The information revealed in this study was based on the most representative sample of service members (Mustillo et al., 2015). All four branches of the military were used—Navy, Army, Air Force, and Marines—and multiple locations Iraq and Afghanistan were explored (Mustillo et al., 2015). This study used self-reports as well as military medical data and military assessments [Post-Deployment Health Assess (PDHA) within 30 days of departure and the Post-Deployment Health Reassessment (PDHRA) between 90 and 180 days after redeployment or return home] (Mustillo et al., 2015). The Health Care Encounter was also utilized to assess service members (Mustillo et al., 2015).

The results of this study confirmed that a high rate of mental health issues was found among service members who were deployed to Iraq and Afghanistan (Mustillo et al., 2015). The Navy is believed to be at higher risk due to their involvement in land combat alongside the Army in spite of only 3 weeks of training (Mustillo et al., 2015). The strength of this study was the sample is representative of all branches of the military.

The limitation of this study was the use of self-reports which might be underreported by service members due to a fear of loss of employment and failure to be promoted (Mustillo et al., 2015). According to Collinge et al. (2012), Mustillo et al. (2015), and Ursano et al. (2016), the gap was the use of active duty, full-time military which did not account for the National Guardsmen and Army Reservists who made up more than half of the service members who were deployed.

Traumatic brain injury. In a study in 2009 and in a more recent comprehensive guide on PTSD in 2016, TBI and PTSD were considered the signature injuries among service members deployed to Afghanistan and Iraq (Burke et al., 2009; Moring et.al 2016). The combination of TBI and PTSD presented a new disability classification for rehabilitation counseling professionals (Burke et al., 2009; Moring et al., 2016). In a study conducted by Burke et al. (2009), veterans were experiencing difficulties in transitioning and reintegrating which led to an inability to maintain employment thereby causing financial distress. This study also found many service members experienced legal problems due to their antisocial and dangerous behavior; there was an increase in domestic violence, child abuse, and substance abuse (Burke et al., 2009).

It was estimated that between 15% and 19% of OIF/OEF service members were affected by TBI which had prolonged cognitive and physiological manifestations such as headaches, dizziness, impulsivity, irritability and poor concentration, difficulty with memory, and confusion and inattention. These conditions led many service members become transient (McDevitt-Murphy et al., 2014; Nelson, Davenport, Spanhein, & Anderson 2015). TBI has been linked to increased rates of alcohol use; cognitive

impairment resulting in inappropriate decision-making was a direct consequence of TBI (McDevitt-Murphy et al., 2014). Rapid mood changes where emotions are displayed such as exaggerated crying or laughing, irritability, or heightened temper outbursts have also been linked to TBI (Nelson et al., 2015).

Many veterans with TBI who survived in the war zone have acquired training and skills, such as driving in a combative manner, that are not conducive to the daily lifestyles they lead at home, in the community, and in the workplace (American Occupational Therapy Association, 2018). Community-based rehabilitation programs focus on improving service members' functionality through social interaction, interpersonal relationships, and independent living skills in the environment in which the service members live **(**American Occupational Therapy Association, 2018). The functionality of the service members with TBI who served in OIF/OEF have been impacted in ways that continue to cause adjustment issues physiologically, psychologically, and behaviorally.

Substance abuse. PTSD is the most frequently studied effect of combat exposure; 19% of service members develop PTSD is within a year of returning home; high risk factors that co-occur with PTSD are substance use disorder (SUD) and aggression (Brown et al., 2012; McDevitt-Murphy et al., 2014; Norman et al., 2018). Approximately 200,000 American troops served in Iraq and Afghanistan. Studies indicate that short-term rates of SUD in that group are higher than the civilian population (Brown et al., 2012). SUD is used as a coping mechanism to suppress the memories and to help sleep (Brown et al., 2012). In this study eight measure were assessed.

PTSD was assessed with the PCL-C, a 17-item self-report measure to see what things bother service members the most. Three items assessed alcohol use over the past 30 days (any use, heavy use, and episodic drinking). Heavy use was the consumption of five or more drinks per typical drinking at least once a week in the past 30 days, episodic was five or more drinks on a single occasion; driving after drinking was defined as driving within 2 hours after drinking any amount of beer, wine, or liquor. Physical aggression was assessed by two questions about the types of aggression (i.e., hitting a spouse, fiancé/e, boyfriend, or girlfriend, or physically hitting anyone not in your family) within the past 30 days. Two questions measured verbal aggression (having a heated argument with a friend or family member or getting into a loud argument in public) in the past 12 months (Brown et al., 2012, p. 1186).

Risk taking/impulsiveness measured on a Likert-type scale ranging from 0 (Not at all) to 4 (Quite a lot) with questions that asked about their tendency to take risks and drug use in regard to prevalence of illicit and nonmedical use of nine categories of drugs: (a) marijuana or hashish, (b) cocaine (including crack), (c) hallucinogens/phencyclidine/ lysergide, (d) amphetamines/stimulants, (e) tranquilizers or other depressants, (f) barbiturates/sedatives, (g) heroin or other opiates, (h) analgesics and other narcotics, and (i) inhalants. Nonmedical use was defined as any use of these drugs either without a doctor's prescription or in greater amounts or more often than prescribed, or for any reasons other than as prescribed, such as for the feelings they caused (Brown et al., 2012, p. 1186). The researcher found that negative behaviors were increased due to increased symptomology necessitating comprehensive assessment beyond the cutoff score of the

PCL-C to include anger management, substance abuse screening, violence propensity, and risky behavior and impulsiveness (Brown et al., 2012).

PTSD and substance abuse in veterans have been researched since the Vietnam era (McDevitt-Murphy et al., 2014). The National Vietnam Veterans Readjustment Study (NVVRS) was commissioned to obtain the rates of PTSD and other mental health issues from Vietnam War; high rates of substance misuse have also been reported among Vietnam veterans (McDevitt-Murphy et al., 2014). The NVVRS estimated lifetime prevalence for alcohol abuse or dependence at 31.2% for theater veterans (OEF/OIF), 23.9% for Vietnam-era veterans, and 17.6% for civilians; these findings indicated there is a greater risk of substance abuse among combat veterans (McDevitt-Murphy et al., 2014). Among OEF/OIF service members, PTSD is the most prevalent mental health issue; both SUD and PTSD are the highest among this group as opposed to other veterans (McDevitt-Murphy et al., 2014). Binge drinking is defined by the number of drinks consumed in a day; a drink is a beer, glass of wine, one cocktail, or shot of liquor (Ursano et al., 2016). Six or more drinks per day is considered binging (Ursano et al., 2016). In this study, the prevalence of these disorders was depression (6.8 %), PTSD (6.7), and binge drinking (11.5%) among 14.8% of enlisted men and 2.6% of enlisted women (Ursano et al., 2016). Substance abuse has proven to be very prevalent among service members of OIF/OEF as a way to self-medicate and forget the negative experiences of war.

Respiratory and sleep disorders associated with PTSD. This war has affected the health of service members in many ways. PTSD has been associated with respiratory

and sleep disorders (Capaldi et al., 2011., 2017; Orr et al., 2018; Slatore, Falvo, Nugent, & Carlson, 2018). In addition to the aforementioned illnesses, service members returning from OED/OIF have experienced high rates of postdeployment lung disease or Iraq/Afghanistan War lung injury, which are several rare respiratory diseases that have occurred in a higher rate than in any other group of veterans ever deployed (Slatore et al., 2018). Service members deployed to OEF/OIF have higher rates of respiratory and mental health issues than those previously deployed; 68% of active duty service members who were referred for pulmonary evaluation complained of mental health issues (Slatore et al., 2018). Another condition that has emerged from OEF/OIF is sleep disruption among those returning home; a recent study of 2,525 soldiers returning home were surveyed for sleep disruption and 30% reported complaints (Capaldi et al., 2011). The rates were higher among those with head injuries, with 58.3% reporting sleep problems. Some evidence suggest that it becomes worse with time; Vietnam veterans reported sleep disturbances as high as 90% or more (Capaldi et al., 2011). Among recently redeployed combat veterans there have been clinically significant sleep disturbances and sleep-disordered breathing problems that are common, but not specific to PTSD (Capaldi et al., 2011).

Reintegration

Reintegration is the process of reestablishing relationships or transitioning back into the roles you filled, personally and organizationally, prior to deployment (Currie, Day, & Kelloway, 2011; Yosick et al., 2012). It is the stage of the deployment cycle characterized by the service member's reentry into his or her daily life as it was prior to

deployment, or into new civilian life, including their personal, professional, and family life aspects (Marek, 2014). Reintegration can be a long and difficult process depending on the individual service member (Marek, 2014).

Reintegration refers to successful functioning in various aspects of life: (a) Psychological health—behavioral, mental, or emotional symptoms or disorders, or psychosocial functioning; (b) Physical health—disease, injury, illness or wellness; (c) Social—interaction with family, friends, parental or marital relationships; (d) Employment—postmilitary unemployment, or jobs; (e) Housing—homelessness, shelter/accommodations; (f) Financial—personal economic situation; (g) Educational—college, continuing education at school, (h) Legal—illegal behavior or criminal justice matters; (i) Spiritual—religious or spiritual activities or sense of meaning in life; and (j) Non-specific-functioning—psychosocial, health, or community-related (Baysigner , 2015; Elbogen et al., 2012; Elnitsky et al., 2017).

Family life. Just as deployment affects every aspect of the service members' lives, so does reintegration (Burke et al., 2009). Reintegration can be extremely difficult for families as they reestablish the family structure; service members experience extreme difficulty in trusting, communicating, and interacting with their family and friends; researchers have identified that it can sometimes be between 4 to 9 months before the negative family function subsides (Marek, 2014; Sayer et al., 2010). One of the primary issues is regaining his or her role within the family structure; while the service member was away, someone else had taken on their role to keep the family functioning (Marek, 2014). Surveys taken of 300 married couples in the Army reported that the stress was

lower for wives, but not husbands, of deployed service members (Allen, Rhoades, Stanley, & Markham, 2011). Among those surveyed, 42% of service members reported having difficulties getting along with their spouse or partners for the first 30 days after deployment, while 35% of them reported separation or divorce during that same time period (Yosick et al., 2012).

Messecar (2017) conducted a study on family reintegration among Army National Guard and Reserves after deployment. In 2013, approximately 1.1 million service members in the Guard and Reserve served versus the 1.37 million active duty service members; the number of deployments was 2.2 with a tour of duty being 12 months per deployment (Messecar, 2017). Service members who served in the National Guard and Reserve were older, married, and were parents, with an occupation other than the Guard and Reserve as opposed to their active duty counterparts (Messecar, 2017). Family reintegration is a process of reentering the family unit and taking on their previous roles; while it is good for them to be home, it can be stressful as many of the symptoms they will experience do not manifest until 3-4 months after their return (Messecar, 2017).

Factors that contributed to the reintegration process were the preparation for the deployment, which involves how well the family is prepared for the deployment. Types of preparation include finding and preparing other support to assist in their absence (i.e., being prepared emotionally), knowing the length and type of deployment (e.g., is it a combat situation or an extended period of time away?), how will communication during deployment be maintained (the frequency, quality, and with whom the communication occurs), and awareness of how deployment changes the service member and family in

ways they might not be aware of until after they are reunited (Messecar, 2017). There are indicators that predict a hard reentry or easy reentry to civilian life: a traumatic event, serious injury, marriage during service, served during 9/11, service in combat, and the injury or death of another service member (Mayo et al., 2013; McDevitt-Murphy et al., 2014).

Some of these overlap with factors to developing PTSD (Mayo et al., 2013; McDevitt-Murphy et al., 2014). As service members experienced role identity issues within the family, the same is true for the reintegration process into the community and workplace.

Community reintegration. In an effort to understand the experience of trauma and the disconnection with family and friends among service members who served in Afghanistan and Iraq, a study was conducted by Ahern et al. (2015). The researchers use homecoming theory and identified three themes: (a) Military as a family, (b) Normal is alien, and (c) Searching for a new normal (Ahern et al., 2015). Service members who served in Afghanistan and Iraq returned home with exposure to traumatic events and many deployments that caused disruptions in their connections with their family and friends and the community. To better understand how to support our service members, I used homecoming theory (Ahern et al., 2015).

Ahern et al. (2015) developed the homecoming theory after WWII to serve as a framework for understanding the challenges of transition from military service. Homecoming theory assumes that the military service member is separated from home by space and time; during the separation, the service member, family, and friends back home

are having unique experiences (Ahern et al., 2015). Both the service member and the people and the environment at home have changed during separation, and in some ways, these will be different and unfamiliar to the service member upon return (Ahern et al., 2015; Marek, 2014). The difference between what is expected and reality for the service member and the family and friends can be a shock for everyone; navigating homecoming involves reestablishing connections despite of changes (Ahern et al., 2015).

This theory emphasizes the theme of disconnection or alienation as part of the challenges service members encounter upon returning home (Ahern et al., 2015; Orazem et al., 2017). *Military as family* explored how the service members experienced military as their "family"; they took care of them and provided structure (Ahern et al., 2015, p. 1). *Normal is alien* refers to the disconnection the service members experience at home from family and friends, institutions; a lack of structure and loss of purpose (Ahern et al., 2015; Orazem et al., 2017). *Searching for a new normal* refers to finding strategies and support to reconnect as well as looking to other veterans as support (Ahern et al., 2015; Orazem et al., 2017).

As a result of this study, the researchers found a lack of support from the military and other institutions, mental health issues were not diagnosed, there were financial difficulties among service members, service members had difficulty making decisions on their own, they experienced alienation and loss of support, many service members took over 1 year to adjust to civilian life and experienced serious issues with sex, substance abuse, and psychopathology (Ahern et al., 2015; Orazem et al., 2017). The researchers strongly encouraged the use of peer-to-peer intervention among veterans and indicated

that more studies were needed to gain information from veterans on how to best serve them (Ahern et al., 2015).

Another study conducted by Elnitsky et al. (2017), indicated that one of the reasons reintegration is difficult is because there is a need for a unified definition of reintegration (Elnitsky et al., 2017). Reintegration has been referred to a transition, readadjustment, community integration, and, finally, reintegration which involves multiple transitions that occur simultaneously to work, family life, and the civilian world from the military world (Elnitsky et al., 2017; Kukla, Rattray, & Salyers, 2015). Transition refers to the time period or process that military service members and veterans (MSMV) move through from a military to civilian setting or the movement through the various health care systems such the Department of Veterans Affairs (Elnitsky et al., 2017). Readjustment is reacclimating to civilian life after deployment. However, it is associated with MSMV struggling with psychological or emotional issues, specifically PTSD; it also has various social issues associated with it such as marital and family issues, homelessness, financial issues, work issues, medical problems, and motor vehicle accidents (Elnitsky et al., 2017).

Community integration refers to returning from deployment, but it is associated with the need for rehabilitation due to severe injuries and, last, reintegration separation from military to civilian refers to returning to the social, occupational, family, and community obligations just as before the deployment (Elnitsky et al., 2017). Due to a lack of a unified definition, there is no real method to successfully achieve it without

knowing what you are trying to achieve. There is a need for more empirical evidence of a unified definition of reintegration (Elnitsky et al., 2017).

Work reintegration. OEF/OIF deployed 1.1 million service members between September 2001 and November of 2007, of which 38% were National Guardsmen and Army Reservists who experienced high rates of interpersonal conflict, PTSD, depression, and overall mental health issues after being deployed (Burnett-Zeigler et al., 2011). Among the National Guardsmen and Army Reservists, 42% experienced the aforementioned issues as opposed to 20% of active duty service members. Active duty service members enter the civilian workforce once they are separated from the military, whereas National Guardsmen and Army Reservists reenter the civilian workforce 14 days (for 31-180 days' tour) or 90 days after (181 days or more tour) (Burnett-Zeigler et al., 2011). Researchers have shown that full-time employment in the civilian arena is lower among individuals who have psychiatric or substance abuse issues (Burnett-Zeigler et al., 2011).

Among individuals with psychiatric disorders, the average number of workdays lost is 6 per month per 100 people and the average of cutback days is 31 days per 100 people (Burnett-Zeigler et al., 2011). The chance of working with mental health issues among veterans is reduced among those with a diagnosis of depression or PTSD, especially female veterans, which has a negative effect on the hourly wage (Burnette-Zeigler et al., 2011; Hamilton, Williams, & Washington, 2015). PTSD is a leading predictor of unemployment and the probability increases as the symptoms increase (Burnett-Zeigler et al., 2011). Very few studies have been performed on service

members who were unemployed and were involved in OIF/OEF. The researchers examined the status of National Guard Service members who entered the civilian workforce 45-60 days after returning home from deployment (Burnett-Zeigler et al., 2011). The researchers took into consideration the number of deployments and their combat exposure, as well as the service members' mental health and misuse of alcohol to examine their employment status (Burnett-Zeigler et al., 2011).

The work reentry period provided a small window of time to identify functionality issues, particularly regarding employment and job training, (Interian et al., 2012; Zeigler et al., 2011). Alcohol misuse was associated with maintaining employment instead of initiating employment (Burnett-Zeigler et al., 2011). Combat trauma was related to unemployment and job loss within 12 months (Burnett-Zeigler et al., 2011). This issue of unemployment had the potential to become a widespread problem for National Guard service members (Burnett-Zeigler et al., 2011). The researchers revealed that mental health issues were not associated with initiating employment; mental health issues were associated with full-time versus part-time employment (Burnett-Zeigler et al., 2011).

Til et al. (2012) conducted a comprehensive study of a systematic review of the literature using 1,267 articles after duplicates were eliminated; three major categories emerged from the in-depth exploration of the articles. The three categories were RTW, employment with the same employer after a short work absence; *supported employment*, entry into the workforce for individuals with severe mental illnesses; and *reintegration*, return to work after a prolonged work absence with mental illness (Til et al., 2012). The RTW category identified four interventions:

> (1) evaluate work situation—identify barriers and facilitators to work; (2) evaluate readiness to commit to RTW—reactivate employment relationships and provide psychological, occupational, and physical conditioning; (3) establish active commitment to RTW—reduce obstacles for RTW and integrate progressive reintegration to work; and (4) maintain work. (Til et al., 2012, p. 1166)

Supportive employment is an entry-level work program for individuals with serious mental illness; the program pairs a job coach with the individual to develop, assist, and train him or her for employment. Supported employment focused on increasing competitive employment with prevocational training and initiating individual placement and support (ISP) (Til et al., 2012).

Reintegration literature was focused on examining which factors had the greatest risk of work absenteeism; some researchers specifically examined PTSD and veterans (Til et al., 2012). A year after hospitalization for serious injury, 30% of the patients with PTSD were working compared to 60% without a diagnosis of PTSD and 20% of patients with comorbid PTSD and depression were working (Til et al., 2012). Patients with PTSD and heroin use had lower rates of employment 2 years out (Til et al., 2012). The findings revealed that there is limited knowledge about how to integrate people with mental illness into a new a workplace after a prolonged absence, and even less is known about integrating veterans (Til et al., 2012).

Kramm and Heinecken (2015) conducted a study on South African youth who joined the South African National Defense Force (SANDF) on a 2-year Military Skills Development System (MSDS) contract experience military service, and the effects this

had on their ability to readapt to civilian life. In 1994, SANDF was replaced by an all-volunteer recruitment system known as MSDS made up of young people between the ages of 18 and 22 and graduates up to age 26 for an initial period of 2 years (Kramm & Heinecken, 2015).

The MSDS focused on preparing the members for a military or civilian career (Kramm & Heinecken, 2015). The moment the recruits entered the military base, the process of de-individualization began, where the needs and wants of the individual was second to the group and obedience to the chain of command was carried out without question (Kramm & Heinecken, 2015; Orazem et al., 2017). The researchers examined military socialization and reintegration as a way to instill discipline in the recruits (Kramm & Heinecken, 2015). The instructors were hard and required a great deal of personal sacrifice from the recruits; this process was often viewed as traumatic and the effects were long-lasting (Kramm & Heinecken, 2015). Essential to the socialization process, recruits were isolated from society for long periods and strict control was exercised over their lives; every activity was rigidly controlled within the 24-hour period from daily life to administrative tasks, the socialization process was found to be dehumanizing (Kramm & Heinecken, 2015). As a result of the aggressive discipline, there were mixed outcomes with some becoming more authoritative and others becoming reliant on authority to function in their daily lives, which posed a problem upon exiting the military (Kramm & Heinecken, 2015.

Researchers indicated many of the members were unable to find jobs when they completed the program or the tour of duty: many of the skills were not marketable, many

suffered traumatic experiences which lead to psychological issues, others resorted to a life of crime as they were unable to find and maintain employment (Hamilton et al., 2015; Kramm & Heinecken, 2015; Kukla et al., 2015; Orazem et al., 2017). At the end of the contract, they received a 5-year contract with SANDF or were placed in the reserve and needed to seek civilian employment (Kramm & Heinecken, 2015). The overall results among 39,053 recruits since MSDS was implemented showed 24,586 (63%) were enrolled full-time into SANDF; 8,286 (21%) left the service, of whom 6,861 sought civilian employment; and only 17% who left opted to serve in the Reserve; the remainder left SANDF without completion of the program reporting various reason such as inability to fit in with the organization's structure or medical fitness (Kramm & Heinecken, 2015).

The problems they experienced with reintegration was anxiety when they would leave home, they needed constant guidance with daily routine, withdrew from family and friends, and found employment skills were not transferable (Kramm & Heinecken, 2015; Orazem et al., 2017). There is a need to understand the impact the military has on the young people and that the unemployment rates double for them after they return to the civilian sector, primarily because they were trained to kill and were left to try to support themselves (Kramm & Heinecken, 2015).

Workplace social support in job satisfaction was explored among veterans with PTSD (Harris et al., 2017). Workplace social support has played an important role in improving vocational adjustment in the general and vocational population, but little research has focused specifically on veterans (Harris et al., 2017). It is important to note that a peer support network among veterans in an important factor in supporting veterans

in getting the treatment needed to obtain and maintain employment (Pfeiffer et al., 2012). Successful rehabilitation for individuals with PTSD involves meaningful participation in, functioning, and satisfaction with major life roles (Harris et al., 2017). Those roles include meaningful work experiences, family life, interaction within the community, and socioeconomic resources (Harris et al., 2017). Effective vocational rehabilitation for veterans with PTSD can improve the quality of life for veterans and reduce the cost to the nation (Harris et al., 2017).

Veterans who were employed with PTSD experienced work days missed due to symptoms, performance deterioration over time, and they lack of social support at work (Harris et al., 2017). The Job Demands and Resources model (JD-R) model was used as a framework to assess the functionality of individuals with PTSD in the workplace; the model evaluated balance of work stressors—physical demands, time limitations, problem-solving, emotional stress and work resources—training, support/tools, supervisory consultation and support, task support, value on work content, social support, as predictors of vocational adjustment, job satisfaction, and work performance (Harris et al., 2017).

Four hypothesis were examined: (a) Workplace social supports served as an additional resource that would result in veterans reporting higher job satisfaction; (b) Veterans with more severe symptoms who were required to manage their PTSD as an additional demand would report lower satisfaction if the variances attributable to workplace social supports were controlled; (c) The workplace social support was modified based on the severity of the PTSD symptoms; and (d) Veterans who received

higher levels of individual social support such as career mentoring, coaching, collegial support, and task support would report higher levels of job satisfaction after the variances attributable to PTSD were controlled (Harris et al., 2017). The result was Hypotheses 1 was supported, accounting for 19% of the variance; Hypotheses 2 and 3 were not supported; and Hypothesis 4 was partially supported; veterans who received career monitoring and collegial support reported higher levels of job satisfaction (Harris et al., 2017).

A clinical trial of 1,292 veterans returning from Afghanistan and Iraq was conducted to explore the prevalence of perceived difficulty of reintegration and compare VA health care users with nonusers (Sayer et al., 2015). Researchers indicated that U.S. service members returning from Afghanistan and Iraq had a high rate of mental health disorders; with PTSD being extremely common with a prevalence of 10.3 and 17% in surveys of combat troops deployed to Iraq (Sayer et al., 2015). TBI was associated with deployment to both locations, Iraq and Afghanistan; TBI increased as the time since the deployment increased which elevated the healthcare needs of these service members long after they were home (Sayer et al., 2015).

In the absence of a diagnoses, transitioning from military to civilian roles was difficult in the major life domains social functioning, productivity, community involvement, and self-care (Sayer et al., 2015). Functioning problems were very prevalent and needed to be understood in order to promote successful reintegration into the civilian arena (Sayer et al., 2015). Service members can use the VA system for up to 5 years of free services for issues related to their deployment. Many service members do

not use the VA system; the majority of service members using the system are nonwhite, of lower socioeconomic status, and have higher levels of disability, major chronic conditions, and obesity (Sayer et al., 2015). The findings of this study were that more than half of the OIF/OEF population reported difficulty with reintegration, binge drinking, and PTSD (Sayer et al., 2015).

In reviewing the literature on reintegration, there are some themes that emerged: OIF/OEF has elevated health care issues both psychologically and physiologically long after the wars end for the service members; the rate of OIF/OEF veterans enrolled in the VA system at higher rates than in previous wars; veterans face difficulty transitioning from military to civilian life; veterans have problems with functionality; they have problems with social functioning, productivity, community involvement, and self-care; veterans face a lack of understanding from the community of the difficulties service members faced; and employers are reluctant to hire service members due to a perceived lack of marketable employment skills.

The impact of PTSD on reintegration. PTSD affects the whole individual. There is not one area of the life of an individual who has a diagnosis of PTSD that is not touched by this disorder (Burke et al., 2009). The physical, emotional, and psychological health of the individual is impaired (Loughran, 2010). Family and friends are affected by the individuals' inability to communicate, tendency to be easily angered, and demonstrated irritation with others **(**Ahern et al., 2015; Messecar, 2017; Yosick et al., 2012)**.** These individuals experience a disconnection with the community regarding changes and the ability to access resources **(**Ahern et al., 2015; Messecar, 2017; Yosick et

al., 2012). Married and non-married couples experienced marital problems and conflicts with one another; the problems ranged from conflicts about reintegration, financial, personal and social challenges fitting back into their community, parenting conflict, and employment. Problems with PTSD and/or depression, chronic injury, and anger impact the ability to obtain and maintain employment which affect the homeless rate of among service members (Til et al., 2012).

Approximately 2 million children have been impacted by parental deployment in support of OIF/OEF with an estimated 220,000 children with at least one parent deployed as of 2013 (Military OneSource, 2016). A study conducted to examine the impact of PTSD on children following parental deployment in which researchers interviewed 169 service members deployed to Afghanistan for 15 months (Foran, Eckford, Sinclair, & Wright, 2017). The researchers examined five dynamics: PTSD and child outcomes; PTSD, general aggression, and child outcome; marital distress and child outcomes; general aggression and child outcomes; and current study (Foran et al., 2017). Service members from Iraq and Afghanistan who were exposed to combat violence, human trauma, and killing were examined for PTSD, general aggression, and child outcomes (Foran et al., 2017). Children who were exposed to a parent's aggressive/angry behavior such as verbal outbursts, angry facial expressions, and/or marital discord might become more sensitized to marital conflict and become vulnerable to these effects (Foran et al., 2017). Data regarding marital distress, general aggression, and child outcomes indicated that marital conflict has been linked to more adults seeking mental health service for the child and the couple in regard to depression and delinquency. Aggression resulted in a

decline in social functioning; children were also found to be more verbally aggressive with other children (Foran et al., 2017). The current study examined the interrelationship between a child and a parent returning home with PTSD, showing it would predict child mental health and that general aggression would mediate the impact of PTSD and marital discord for both the child and the service member (Foran et al., 2017). In this chapter, I provided an overview of the literature reviews for this qualitative research. There were eight major themes that evolved from this literature review: PTSD and diagnoses, factors that contribute to PTSD, stigma associated with PTSD, PTSD and co-occurring mental health issues, respiratory and sleep disorders associated with PTSD, reintegration and impact of PTSD on reintegration. Literature indicates there is a need for more research about how to assist service members in the reintegration process. Chapter 3 provides the methodology for this study a description of the research methods, design and rationale, the researcher's role, data collection and data analysis, procedure, and the RQs, evidence of trustworthiness, results, and summary.

Summary

OEF and OIF have combined to form the longest war ever fought by the United States to date. According to the Congressional Budget Office reports published in 2017, these wars have cost the US $2.4 trillion dollars. The real impacts of this war are the physical, emotional, and psychological impacts it had on the service members, their families, and their communities. The impact that PTSD has played on the reintegration process for service members could have a lifetime prevalence just as the Vietnam war had on its veterans.

Through the examination of literature for this study, some themes emerged. Service members experienced difficulty transitioning from military to civilian roles in the workforce. Problems after deployment included social functioning, community involvement, and self-care; high rates of mental health issues among service members; high rates of reintegration issues among service members and their families; and high rates of unemployment due to PTSD. These were the most prevalent themes that emerged in this examination of the literature. The literature showed gaps indicating the need to better understand the reintegration process for service members with PTSD after deployment, especially in regard to employment. and best practices for working with service members with PTSD who are unable to work full-time due to symptoms of PTSD. This qualitative hermeneutic phenomenological study explored the lived experiences of service members with PTSD who are experiencing challenges with work reintegration. The purpose of this study was to bring meaning and understanding to the clinical, and academic community as to the best practices needed to assist this population with successful work reintegration from the perspectives of service members.

Conclusion

While this research has explored various factors that contributed to the development of PTSD and its impact on reintegration, there is still much more to be explored in this arena. There is a need for more research on service members with PTSD, the challenges they face with reintegration, and the ability for reservists and guardsmen to easily access healthcare, housing, employment, social support within the community. The full impact of this war has not yet come to an end and much more is needed to

expand the knowledge of mental health professional and the academic arenas to better serve this population. I believe this study has broadened the knowledge base on this topic and will inspire others to initiate other needed studies.

Chapter 3: Research Method

The purpose of this hermeneutic phenomenological study was to gain an understanding of the lived experiences of service members with PTSD who face challenges reintegrating into their civilian workplaces. There is a need for more research regarding employment reintegration with service members (Resnik et al., 2012). By sharing their perspectives on the challenges they experienced as they reentered the workforce, participants may provide insight to help clinicians in developing best practices to work with this population. Findings from this qualitative study may also be the basis for research on other reservists and guardsmen.

In this chapter, I describe the qualitative method and design that I used to gain an understanding of the experiences of Iraq War veterans with PTSD. I also describe the participants and the recruiting process for this research study. I outline the procedures for data collection and analysis, verification of the findings, and ethical considerations. I sought to gain a better understanding of the lived experiences and perceptions of barriers of service members with PTSD who face employment reintegration challenges.

Research Design and Rationale

I conducted a hermeneutic phenomenology study to understand the lived experiences of Iraq War veterans with PTSD who are currently experiencing work reintegration challenges. Hermeneutic phenomenology focuses on bringing meaning and understanding to individuals' lived experiences (Kafle, 2012; Moustakas, 1994). The subjectivity of the participant is valued in hermeneutic phenomenological studies (Cohen et al., 2000). Gaining insight on participants' subjectivity and perceptions may clarify

what is needed to assist them effectively with reintegrating into the workplace successfully.

Hermeneutic phenomenology concerns what people do and say, what people write, and what language people use (Cohen et al., 2000). Language is important because service members have a language of their own (Cohen et al., 2000). Use of this phenomenological design allowed me to explore the challenges faced by service members with PTSD as they return to the workplace and helped illuminate preconceived barriers to successful work reintegration from the perspectives of service members.

A better understanding of the identified barriers, lived experiences, and perceptions of service members with PTSD who face employment reintegration challenges could help counselor educators determine the necessary skills to assist these service members in regaining a sense of purpose through employment. Based on the participating service members' accounts of their experiences, this hermeneutic phenomenological study provides comprehensive details of the challenges faced regarding employment reintegration. This empirical knowledge may help clinicians identify skills to help service members or assist counselor educators in training counselors to work effectively with the growing population of returning service members with PTSD who need help to reintegrate in the workplace successfully.

Qualitative methodology is a form of social inquiry that can be used to explore the lived experiences of the participants (Cohen & Crabtree, 2008). Qualitative research is interpretative as the researcher uses it to gain insight into the way people interpret and make sense of their experiences and the world they live in (Cohen & Crabtree, 2008).

Qualitative research is nonmanipulative and naturalistic; it occurs in real-world social settings (Patton, 2002). The qualitative methodology aims to bring a deeper understanding by truthfully reporting participants' firsthand accounts of their experiences and through observation of the researcher (Patton, 2002).

I considered other qualitative methods of inquiry for this research study but concluded that they would have been less effective in providing the rich, deep details needed to understand the experiences of participating service members. Researchers use ethnography to examine and interact with cultural groups in their natural settings over an extended period, collecting data through observation and interviews (Creswell, 2009); this type of study was inappropriate because this research focused on the current experiences of participants and not on what occurs over time as it evolves. Researchers conducting grounded theory studies seek to derive a general theory based on the data they collect (Creswell, 2009). During data collection, researchers refine information into categories; this type of study was inappropriate because its focus is on developing theory rather than on understanding the experiences of participants (Creswell, 2009).

A case study is an intensive study of a group, event, program, or person over a prolonged period (Creswell, 2009). This type of study requires an extensive amount of time and activity (Creswell, 2009). Narrative research is an inquiry that provides a story about the person that is retold in chronological order; the end result is a collaboration of the participants and the researcher (Creswell, 2009). Narrative research was inappropriate for this study because my focus was not on collaborating with the participants to frame their view of the study phenomenon; rather, my focus was on

analyzing the experience of reintegration for service members. Phenomenology provides a description of a person's or a group of peoples' stories about their experiences; it focuses on the commonalities among the group regarding their experiences (Creswell, 2013). Researchers use transcendental phenomenology to describe individuals' experiences (Creswell, 2013). Transcendental phenomenology was inappropriate for this study because generating meaning and understanding, rather than describing the service members' experiences, was the focus of this study.

I opted to conduct a hermeneutic phenomenology study. Hermeneutic phenomenology focuses on the lived experiences of others and how these are interpreted to bring meaning and understanding (Cohen et al, 2000). By understanding the commonalities of individuals' experiences, useful information can be gained to develop training guides, best practices, and policies that can enhance the service received by service members as they reintegrated into civilian workplaces.

Research Questions

To gain an understanding of the lived experiences of service members with PTSD who face work reintegration challenges, I asked the following questions.

RQ: What are the lived experiences of Army Reservists and National Guardsmen with PTSD who served in Iraq or Afghanistan and are currently undergoing work reintegration issues?

Subquestion: What are service members' perspectives on aspects of the workplace environment that inhibit successful reintegration?

Role of the Researcher

In qualitative research, the researcher is the instrument; in this role, the researcher performs many aspects of the research process (Patton, 2015). It is important that research be credible and dependable (Cohen & Crabtree, 2008). I demonstrated credibility as I accurately and truthfully reported the data gathered through the observation and interviewing process. As I engaged in this process as a participant observer, I strove to develop rapport with the participants to enable free-flowing responses to the semistructured interview questions. I systematically collected data which contributed to the dependability of the study (see Cohen & Crabtree, 2008). To systematically collect data, I conducted face-to-face interviews with open-ended interview questions that were relevant to the topic. All interviews were conducted using the same interview questions, in the same order, for 90 minutes (see McNamara, as cited in Turner, 2010). All interviews were audio-recorded and transcribed verbatim (see Sutton & Austin, 2015). I also observed participants at centers serving veterans (see Elmusharf, 2012). As the researcher, I was responsible for design the study and the interviewing, transcribing, analyzing, verifying, and reporting of the data for this study.

I selected the participants of this research study based upon the selection criteria set forth in the "Methodology" section of this chapter. To reduce bias, I excluded participants whom I had encountered personally or professionally. Bracketing is a methodological tool used in phenomenology that requires the researcher to intentionally put aside their personal beliefs about the phenomena that are being examined; throughout the research process the knowledge already known must be put aside (Chan, Fung, &

Chien, 2013). I used bracketing to ensure that my personal beliefs, values, and perceptions did not influence the study (Chan et al., 2013). To increase the reliability of this study, the interviews were recorded with an audio-recorder, transcriptions were written and compared to ensure accuracy and themes, and clusters were coded.

Methodology

Participant Selection Logic

Participants included Army Reservists and National Guardsmen from the state of Alabama; the population for this study ranged in age from 30-59. The participants included both male and female service members from all ethnicities who met the inclusionary requirements and were willing to participate. The inclusionary requirements for participation in this research study included (a) service members who deployed to Iraq, Afghanistan, or both for 6 months or longer; (b) service members must have a diagnosis of PTSD; (c) self-identified as currently experiencing problems with work reintegration; and (d) must be an Army Reservist or National Guardsman from Alabama. I recruited six service members from local centers serving veterans. Meetings with the representatives from the centers serving veterans were scheduled to provide information about the study. All participants referred by the centers were screened to ensure they met the prerequisites. The recruitment process included an e-mail sent to the centers' representatives describing in detail the purpose, risks and benefits, methods, and inclusionary and exclusionary criteria for the study. I asked center representatives to post flyers and send the flyer to their service members via e-mail through their listserv. Interested service members were asked to e-mail me to discuss the details of the study

and if they were eligible they electronically consented with a "I consent." In qualitative research, saturation can be obtained with 6 participants because of the rich and deep data (Mason, 2010). The study began upon approval from Walden University's Institutional Review Board (IRB; approval no. 08-29-19-0303-405). The IRB board reviewed all aspects of the plan to ensure that the participants of this study are protected. The data collection process occurred over 60 days, to account for any unforeseen circumstances that might arise.

Inclusion criteria. The inclusionary criteria for this study consisted of Alabama Army Reservists and National Guardsmen who deployed to Iraq, Afghanistan, or both for 6 months or longer. They had a documented diagnosis of PTSD and were between the ages of 30 and 59. This study included males and/or females of any ethnicity. The service member self-identified as experiencing problems with employment reintegration.

Exclusion criteria. Any Alabama Army Reservists or National Guardsmen that I knew personally or professionally were excluded from this study. Service members from any other branch of the military or from outside state of Alabama were excluded. Active duty service members were excluded.

Sampling. The sampling methods for this phenomenological research study were purposive homogeneous and snowball sampling to recruit the 6 participants for this study. Purposive sampling is relevant to qualitative research as its goal is to focus on particular characteristics of a population of interest (Laerd, 2012). Snowball sampling is a nonprobability technique where participants in an existing study refer or recruit other participants among their friends or acquaintances (Laerd, 2017). Purposive homogeneous

and snowball sampling were the best choices for this study as I was sought to explore the experiences of particular people within an identified population that are difficult to access (Laerd, 2012).

Instrumentation

In qualitative research the researcher is the instrument. I developed a 12-item instrument as an interview guide (see Appendix A). The instrument was designed to collect concise personal information on the participants. The semistructured interview questions were formulated to collect information about the participants' diagnosis, treatment history, family, deployment, postmilitary experiences, and the challenges they faced as they reintegrated to the civilian workforce. My goals for the interview protocol were to conduct face-to-face interviews at the centers serving veterans, ask questions that were relevant to the research, and keep the interview focused. Open-ended questions were used to create more freedom for the participants to openly discuss their experiences in detail, creating rich, thick data (Patton, 2015). The interviews were audio-recorded. To establish content validity, I read existing literature directly related to my research before developing a 12-item instrument protocol to compose questions that would examine the areas of the participant's experiences directly related to the RQs. I incorporated interview protocol based on Jacob and Furgerson's (2012) and McNamara's (2009, cited in Turner 2010) interview protocols for conducting research to ensure proper etiquette was implemented during the interview process. Jacob and Fugerson's protocol are (a) start with a script; (b) collect consent; (c) use a recording device and take brief notes but maintain eye contact with interviewee; (d) arrange for a quiet, semi-private

place to interview; (e) block plenty of uninterrupted time for the interview; (f) use basic counseling skills to help the participant feel heard; (g) have genuine care concern and interest for the participant; (h) stay focused; (i) listen, listen, listen; and (j) end with the script. McNamara's (2009) as cited in Turner (2010) interviewed protocols are (a) verify the tape recorder is working; (b) ask one question at a time; (c) be neutral during the interview; (d) occasional nods of head shows your attention and encourages responses; (e) be careful about the appearance when taking notes; (f) provide transitions between major topics; and (g) always guide the interview.

Procedures for Recruitment, Participation, and Data Collection

Prior to the recruitment process, I submitted my proposal to the IRB for approval to ensure that the protocol for research working with human participants had been thoroughly planned prior to implementation (approval no. 08-29-19-0303-405)**.** The procedures for the recruitment process and the dissemination of information to the participants, collection and analysis of data, and the validation process were as follows. The local centers serving veterans were contacted via telephone to provide information about the study and set up a meeting with the centers' representatives. The representatives received an e-mail (see Appendix B) that provided details about the study in full, indicating the inclusionary requirements, purpose, risks, and benefits of the study along with the Informed Consent Forms to review. The centers' representatives were asked to post flyers in their centers as well as e-mail the flyers via their listserv (see Appendix C). Those interested participants replied to the e-mail and follow-up calls were made to determine eligibility. Once eligibility was confirmed, participants signed an "I

consent" and interviews were scheduled for a 90-minute face-to-face interview at local libraries and a veteran's center. Field notes were written within 24 hours of the observation of the participants on an interview sheet I developed to ensure accuracy. Semistructured interviews were used to gather information. Audiotapes of each interview and verbatim transcripts were utilized and analyzed. Participants were sent a copy of their transcript to review for member checking to ensure accuracy and provide validation of the accuracy of the data collected from the service member.

Data collection plan. To collect data for this hermeneutic phenomenological study, I used semistructured interviews, memos, and observations. Interviews were the primary tool used to collect data; all interviews were audio recorded to ensure accuracy. According to Moustakas (1994), interviews are the main tool used to collect data in phenomenological research studies. Interviews can elicit various types of data depending on the kinds of questions asked (Cohen et al., 2000). Open-ended questions were used to promote richer, more detailed data as the participants were free to elaborate about their experiences pertaining to the RQs. The semistructured interviews were conducted at local libraries and centers serving veterans for 90 minutes. Following the semistructured interviews, data were transcribed. An interview guide was used to ensure that all participants were asked the same questions in the same order. The interview questions were developed and formatted to gather the most relevant information about the topic.

All interviews were stored in a secure folder password protected on my computer. All participants were assigned identification codes to ensure confidentiality. Verbatim transcripts were sent to each participant for member checking for accuracy; once member

checking was completed participants were done with the study. Memos were written within 24 hours of the observation on the interview sheets. Participants' interviews were scheduled at the veterans' center between 30 and 60 days. A reflection journal was maintained during the interviewing, memo, and observation process to help eliminate biases.

Data Analysis Plan

The data analysis process in hermeneutic phenomenological research moves from field text that is obtained through data collection to a narrative that is independent and can stand alone for others to read (Cohen et al., 2000). This process of data analysis occurred throughout the entire study, reading and rereading the field text in various ways and in no particular order (Steeves & Kahn, 1995). I used Cohen et al.'s (2000) data analysis techniques, which were a modified version of van Manen's (1984, 1994).

This strategy has six steps. The steps are (a) actively listening and thinking about the meaning of what is being said and developing labels for the meaning that is developing, (b) researcher immerses themselves into the data and starts the initial interpretation of data that will direct the coding of data, (c) data transformation or data reduction based on the researcher's determination of the relevance of the data, (d) line by line coding, (e) thematic analysis of text for understanding highlighting phrases for the development of themes, and (f) writing and rewriting narrative (van Manen, 1994). NIVO software was used to analyze the content and for coding. Memos, observation, and my reflection journal were also entered into the NIVO software. I developed labels

for the meaning that began to develop during the interviewing process; as the data evolved in greater detail, I began to eliminate data that were not relevant to the topic.

Research conducted by Sajjadi, Rassouli, Abbaszadeh, Brant, and Majd (2016) utilized van Manen's (1994) phenomenological approach to interview and convey the lived experiences of individuals dealing with the uncertainty of cancer. van Manen's method of verbatim transcription was also used to analyze data on the lived experiences of resilience of adolescents living in residential care facilities (Nourian, Shaahbolaghi, Tabrizi, Rassouli, & Biglarrian, 2016). This study utilized the modified version of van Manen's method of analyzing data that was adopted by Cohen et al. (2000) to interview, analyze, and code the experiences of service members with PTSD who face employment challenges. To ensure the accuracy of data, I used member checking with the participants and revised and transcribed the responses as needed. I also compared the transcription of the raw data with the audiotapes to ensure accuracy and validation.

Issues of Trustworthiness

Trustworthiness

In qualitative studies, it is important to establish trustworthiness. According to Lincoln and Guba's evaluative criteria there are four components in establishing trustworthiness (Cohen & Crabtree, 2008).

Trustworthiness involves credibility, transferability, dependability, and confirmability, according to Cohen and Crabtree (2008). Credibility is confidence that the research findings are true (Cohen & Crabtree, 2008). I established trustworthiness by providing an environment that promoted rapport building and encouraged participating

service members to respond truthfully to the interview questions and provide detailed information that promoted understanding of their lived experiences. Bracketing was used to ensure that my personal beliefs, values, and perspectives did not influence the study. Member checking is a process when the data, analytic categories, interpretations, and conclusions are verified with the individual it was obtained from to ensure accuracy (Cohen & Crabtree, 2008). Member checking was used at the end of the transcription process to ensure that the data provided by the service member were accurately reported; this process also helped in verifying the researcher's observations as the service members gave explanations of the observed behaviors or patterns (Shenton, 2004). According to Lincoln and Guba, member checking is a vital component in establishing credibility.

Transferability

The second component in establishing trustworthiness is transferability. Transferability is showing that the findings of this study can be applicable to other contexts (Cohen & Crabtree, 2008). According to Creswell (2013), transferability is not the most crucial component in qualitative research. I provided thick, rich data which, being understood by the reader, may be compared and transferred to other contexts, depending on the setting or group (Shenton, 2004).

Dependability

The third component of trustworthiness is dependability, which is established as the findings of this study are stable and can be repeated (Shenton, 2004). If the study is repeated using the same context, using the same participants, with the same methods, the

results should be similar (Shenton, 2004). To address dependability, I reported all data in detail and systematically laid out the procedures used to collect data (Shenton, 2004).

Conformity

The fourth component of trustworthiness is conformability which is established through neutrality of the data and not influenced by the researcher's biases or motivations (Cohen & Crabtree, 2008). The use of one method when others are available must be explained and the weakness must be disclosed when establishing conformity (Shenton, 2004). I addressed conformability by keeping a reflective journal and through the use of bracketing. Lastly, I compared raw data categories with the data categories from NVivo to ensure accuracy.

Ethical Procedures

Researchers involving human participants must give great consideration to the well-being of the participants and anticipate any potential harm (Creswell, 2013). The first step in this process is to obtain approval from the Institutional Review Board (IRB). I reviewed the American Counseling Association (ACA) Code of Ethics regarding human participants informed consent procedures and implemented the informed consent process (Creswell, 2013). I enforced confidentiality procedures for all service members. I acquired permission from the centers serving veterans to go on site and utilize their facilities; while at the site I was respectful of and sensitive to the individuals and the property (Creswell, 2013). I was respectful of the service members' limitations and disclosed all of the information regarding the study. I demonstrated ethical integrity to the service members and others who assisted in the recruitment process. The language

used in the research study was clear and straightforward to expedite the process and ensure accuracy (Creswell, 2013). I implemented best practices by protecting the interest, well-being, and confidentiality of the service members at all times. There was no known physical risk to service members due to this study. There was the potential for emotional distress due to recall as they disclosed their experiences about their work reintegration issues. I contacted the necessary services on behalf of the service member if distress was detected or revealed during the interview process. In accordance with Walden's University Research Department, the informed consent consisted of the following characteristics: (a) the purpose of the research, (b) the risk and benefits of the research study, (c) the expectations of the service members and the duration of the study, (d) the voluntary nature of the study, (e) confidentiality procedures, (f) how the information would be used, (g) the contact information for the researcher, (h) the contact information for the research participant advocate for Walden University. Informed consent was obtained from all service members prior to the study. The research participants were informed that there was no cost or compensation for participating in this study. The participants were informed that there was a possibility of publishing the research from the interviews. Printed copies were made available to participants upon request. All information will be stored on my computer for 5 years; after that time, I will delete all of the data on the computer and shred the printed copies. The transcribed and recorded data were compared for accuracy and validation (Creswell, 2013). Participants had the right to withdraw from the study at any time without reprisal and their information would be deleted.

Summary

In this chapter, I have provided an overview of the research design methods for this qualitative research study. This chapter began with a brief introduction followed by the rationale for hermeneutic phenomenological study. This chapter explained the research design including details regarding role of the researcher, the inclusionary and exclusionary requirements of the service members, and a description of the collection and analysis procedures were outlined. Last, this chapter discussed issues with trustworthiness and ethical concerns of the study. Chapter 4 provides a review of the data collection methods and the findings of the study. It provides a description of the setting where the study was implemented and relevant demographic information about the service members.

Chapter 4: Results

The purpose of this hermeneutic phenomenological research study was to understand the lived experiences of service members with PTSD who had experienced work reintegration challenges. In addition to revealing the challenges service members with PTSD face during the reintegration process, this study may also provide some insight on best practices for counselors serving this population. The findings revealed that there is a disconnect between counselors, the military, family members, the communities of service members, and employers on what is needed to provide the necessary treatment and support for successful reintegration into the workplace. In this chapter, I discuss the setting, demographics, data collection and analysis, and trustworthiness of data and present the results.

Setting

Interviews with the participants took place in three locations. Four of the interviews took place at local libraries in reserved private study rooms. One took place at the Veterans' Center in a reserved private office. One participant needed a location closer to their home, and the alternate location was a reserved private room at the library closest in proximity to the participant. I reserved all the interview rooms and the office space in advance and provided the information to the participants before their arrival to ensure privacy.

Demographics

Participants in this study consisted of six service members, of whom four were male and two were female. Three were officers, and three were enlisted personnel.

Participants' ages ranged from 30 to 59; four were African American, one was Italian, and one was White. All participants served from 4 to 27 years in the military. All participants lived in Alabama. Four of the participants were deployed to Iraq, and two were deployed to Afghanistan. Each participant in the study deployed from 8 months to 1 year. Five of the participants were college graduates, and one participant enlisted out of high school. Participants provided details about their lived experiences during their deployments and the challenges they encountered as they returned home and began the reintegration process. From their detailed descriptions, four themes emerged: reexperiencing the trauma, reconnecting with others, difficulty performing or maintaining employment, and a need for knowledge among counselors to development best practices.

Data Collection

I collected data by conducting six face-to-face interviews with each participant for 90 minutes of audio-recorded interviews. Five of the interviews took place at local libraries in a reserved private room, and I conducted one at the Veterans Center at a local university. There was one encounter where the participant became tearful and another encounter where the participant cried as they recalled their lived experiences during the reintegration process; these displays of emotion did not influence the results of the study. I manually transcribed the data and used NVivo to assist in the organization of data and the identification of similarities in words, phrases, and patterns.

Data Analysis

The interviews were the tool used to collect data. Therefore, I digitally recorded each interview to ensure the accuracy of each participants' transcript. Cohen's (2000)

analysis of data begins with understanding parts of the text in relation to the whole text and vice versa; the investigator considers the meaning of small units of data. In concordance, as I collected the data, I began to consider the meaning of the smallest units of data as they increased to larger units during the process. I analyzed parts of the data to gain an understanding and continued until I had examined and gained an understanding of all the data. According to Cohen in the analysis of hermeneutic phenomenology, the researcher codes the data, develops themes, and assigns labels to data. Therefore, I examined each line of data and coded data to develop themes and meaning of the entire encounter; once I understood the data, I underlined phrases and wrote tentative themes and assigned labels.

According to Creswell (2013) and Patton (2015), data in qualitative research should be rich, thick, and detailed. In qualitative research, coding the data helps the researcher to identify similarities in words, phrases, and reoccurring segments of information. Therefore, during this phase of the analysis, I coded words, phrases, and reoccurring segments of information to label and develop themes. I used a color-coding process to group similar patterns, words, or phrases to identify the themes found in the data. I also used a number coding process to identify the participants' rich, thick descriptions of their lived experiences. I used NVivo to help highlight similarities and to organize, sort, and store data. Four themes emerged from the data collected. Those themes were reexperiencing the trauma, reconnecting with others, difficulty performing and maintaining employment, and a need for knowledge among counselors to develop best practices.

Evidence of Trustworthiness

To ensure the trustworthiness of this study, all participants took part in member checking to ensure the accuracy of the data. Additionally, I attended to credibility, transferability, dependability, and confirmability of the results. I used an interview protocol with all the participants using the same questions, in similar settings, using a semistructured interview process. All the participants engaged in a 90-minute interview and answered and discussed their lived experiences of deployment and reintegrating into the workplace after returning home. Credibility was established through the data obtained from the audio-recordings and field notes. Credibility is the researcher's confidence that the findings are true. No adjustments were needed in the credibility process. After each transcript was completed, it was sent to the participant for member checking to ensure accuracy. Transferability occurred during the manual transcription of the participants' interviews. The interviews denoted similar patterns of behavior, symptoms, and experiences. No adjustments were needed in the transferability process in this study.

Dependability of the detailed, systematic accounts of the lived experiences of the participants, the methods, and the same context can ensure replication of this study. This study can be a resource to the military and the service members' families, employers, and counselors. It also may be instrumental in promoting future studies on the topic. Confirmability was achieved through member checking; all participants deemed the results accurate and acceptable from their perspectives.

Results

The purpose of this hermeneutic phenomenological research study was to gain an understanding of the lived experiences of service members with PTSD who faced employment reintegration challenges. This study provided understanding and awareness of best practices that can be used by army leaders, employers, community leaders, and counselors of service members in serving this population. These best practices include four recommendations: (a) develop an advisory board that consists of veterans, counselors, and the VA to provide input on treatment, resources, and support services; (b) develop a peer support group for veterans and their spouses to assist them in the reintegration process; (c) develop a veterans' consulting group for local employers to use when service members return from deployment; or when veterans are having difficulty on the job and might benefit from talking to a fellow veteran about their concerns; and, (d) last, develop quarterly community round tables to educate family, friends, employers, and the community on the process of deployment and its impact on the service members and their families. These round tables would provide an opportunity for service members and their families to educate others by sharing their stories, challenges, and victories they have won during the reintegration process. These are the recommendations for best practices based on the findings of this study for counselors, family members, employers, the community, and the army, when assisting service members with the necessary treatment and support for successful reintegration into the workplace. All the participants in this study chose to serve their country through full-time active duty in the Army, Army Reserve, or the Army National Guard.

According to Lancaster et al. (2014), service members are four to five times more likely to develop PTSD due to deployment; there are psychological stress symptoms that are related to deployment and the anticipation of deployment. Participant 065 reported the stress associated with preparing for deployment is something the public needs to be educated on due to the enormity of the process and its impact on service members and their families. During deployment, stressors faced by service member such as explosive devices (IEDs), ambush and attacks from combatants, the loss of life of others, and always being on the alert were directly associated with the development of PTSD (McDevitt-Murphy et al., 2014). The length of deployment is also associated with the development of PTSD; the chance of developing PTSD increases by 2.2% for those deployed over 180 days (Shen, Arkes, & Pilgrim, 2009). Participant 065 confirmed that the type of experiences and the length of the service members' deployment directly impacted the development of PTSD, in particular among those who are in combat situations. All participants in this study reported that they had no symptoms of PTSD before their deployment; they became symptomatic during or after they returned from their deployment. Through the literature review, I found that individuals with PTSD exhibited various symptoms such as flashbacks, nightmares, inability to sleep, difficulty concentrating, hypervigilance, irritability, and being easily startled (Jones et al., 2007; Loughram, 2010). These symptoms can last for years after the event and many times never go away. For example, participant 62 stated, "I had nightmares, sleepless nights, jumping out of bed thinking I was still engaged in the fight." He also talked about his inability to focus at work: "Ah, after a restless night and dreams, the next day it kind of

sticks with me, and it hindered my ability to focus and do what I needed to do." He also reported one of his most daunting recurring nightmares was when one of his soldiers was killed. "I held his hand until he took his last dying breath, and I had to put him in a body bag. That scene is still with me until this day."

Participant 063 reported that he had no physical or mental health concerns until "back in the Gulf War when I was thrown in combat action, it brought out the PTSD, and with every deployment, more symptoms occurred." He had night sweats, difficulty sleeping, and nervous twitches. Participant 065 stated, "I isolated myself in my own little world." Participant 066 noted his symptoms began during his deployment to the Gulf War; but during his last deployment to Iraq, he stated, "I had anxiety, anger issues, and other stuff like that. PTSD, it was crazy; it was chaos." Participant 067 reported she had no symptoms before her deployment until "that suicide bomber's vehicle exploded; it had an impact on me." She experienced nightmares, flashbacks, and difficulty sleeping.

Life in a war zone took a toll on service members; there was extreme stress for medical personnel, mortuary workers, and persons from other occupations requiring the service member to be on guard constantly (McDevitt-Murphy et al., 2014). For example, Participant 064 reported, "You are on guard 24/7, you have an M16 on you at all times. The only time my gun was not on me was when I was at the gym." Participant 067 also reported that her gun was on all the time. She remembered the army sponsored a dance for the service members; "They had a dance for morale building for some holiday, and our M16s were clashing up against the M16 on the person dancing beside us. The only time I didn't have my gun was when I was in the shower." Vogt et al. (2016) conducted a

study to examine the quality of life of men and women who served in Iraq and Afghanistan; it revealed that impairment was evident in the individual's ability to function as a parent, spouse or partner, and employee. While participants in this study confirmed they experienced impairments in these areas, it does not mean that they cannot function more effectively in these areas with the proper treatment and support.

According to Murphy et al. (2018), females displayed higher rates of intrusive thoughts, distressing dreams, flashbacks, avoidance of reminders, negative emotional state, diminished interest, and exaggerated startle responses to situations that occur in their normal daily routine the two female service members in this study reported incidents that startled them. Participant 067 was easily startled after her deployment. She recalled a day when she was out shopping with a friend:

> The door slammed shut, and it made a huge loud noise. I took off running and went in the dressing room, cause in my mind when that door hit, we were back in Afghanistan, and that was a mortar hitting the ground or something.

Participant 064 reported that the weather sirens trigger her flashback because they remind her of incoming rocket attacks.

Theme 1: Reexperiencing the Trauma

The first theme focused on trauma; participants shared their personal experiences with trauma. Participant 065 commented, "The severity of deployment is different for each person depending on daily combat versus non-combat, the duration, and casualties." According to participants in this study, they often reexperienced trauma long after the initial traumatic event occurred. Participants in the study had experienced residual effects

of their deployment such as flashbacks, insomnia, and difficulty adjusting to their families during their reintegration journey. During the interviewing process, five of the six participants reported experiencing some common, frequently recurring symptoms such as nightmares, sleepless nights, flashbacks, and night sweats which led them to relive the trauma.

Participant 062 was deployed 16 times between his full-time active duty enlistment and his reserve duty and he was involved in 42 explosions. He described his deployment to the Suwi Triangle of Death in Iraq as a "horrible place, just imagine you feel like an animal every day, you are being hunted by people who want to kill you, and you are hunting the enemy to kill or capture them." He was a squad leader who was "in charge of three-gun trucks (Humvee vehicles); two had machine guns, one had an M60 machine gun, the other had a bravo, and the other had a Mark 19 which was an automatic grenade launcher." He discussed one of the biggest threats during this deployment was to avoid road bombs; he experienced the loss of five soldiers in one road bomb. This explosion was so destructive that they were "unable to find whole body pieces or pieces of the vehicles."

When Participant 062 returned home, he often relived certain episodes from his deployment and saw images of friends who were killed. He recalled one experience where one of his soldiers was killed and he "held his hand until he took his last dying breath and then had to put them in a body bag." He reported that soldier and that situation has stuck with him, and that it is a part of the recurring nightmares he has experienced over the years. Further, after that soldier's death, he and a fellow soldier vowed to kill

everything in sight: men, women, boys, and girls. This experience was so intense that it brought about a shared desire to seek revenge. That pain was so blinding that they were unable to see past the desire to kill everyone and everything in sight. And that blinding pain stays with him and contributes to his trauma. As a result of his deployment experiences he relived the trauma; “I had a lot of nightmares, sleepless nights, and jumping out of bed and crawling on the floor thinking that someone was after me and I was still engaged in the fight.”

Participant 063 was deployed to Iraq to a place called Anaconda, nicknamed Mortaritaville because of all the mortars that were fired by the Iraqis. His unit made numerous missions in the surrounding area where they experienced gunfire and IED explosion at the site where they were making a recovery. Upon his return home, he experienced nightmares: “I relived the deployment scenarios over and over, night after night, I was sleep deprived; and I had night sweats.”

Participants 064 gave an account of her experience while deployed to Afghanistan. She reported, “Life was totally different; all females, military or native, had to be covered up at all times even though the heat was unbearable.” She stated that she was on-guard constantly and had to have her gun with her at all times except when she went to the gym. She reported that getting a cup of water was an ordeal, “You have to examine the water and ice for color and smell before you drink it along with incoming rockets which were a constant thing.” Once she returned home, she experienced nightmares; when the weather sirens went off, it triggered flashbacks of incoming rocket attacks. She also had trouble sleeping to the extent that she was prescribed medication

and a CPAP machine to assist her with sleeping. She reported since being deployed and returning home that she was easily agitated. For example, little things such as popping gum and clicking an ink pen made her anxious and unsettled.

Participant 066 gave an account of his experiences of reliving the trauma. In his position, he was responsible for ordering soldiers out on missions, and he recalled going out with the troops on one mission. While on this mission, he saw a local man near the bridge. He did not know who he was; the troops proceeded across the bridge on the mission. When they came back the man stopped them and told them not to go across the bridge, go around the bridge. This Iraqi man stopping them triggered flashbacks from his tour in the Gulf War where he was involved in direct combat. During his tour in the Gulf, Participant 66 experienced death, devastation, and horrific sights of the Iraqis who had been bombed with napalm and the massive injury it caused. He began to think about the possibility of death for him and his soldiers.

Participant 066 told the troops to “lock and load.” They had the man to go first. Participant 066 told the man, “If this bridge blows, you are going to die with us today.” The man turned out to be a friendly instead of the enemy. This experience, as well as others, resulted in his experience of nightmares, night sweats, and anxiety. His nightmares were so intense that he would wake up swinging and hollering, believing he was still engaged in war. As a result, he temporarily moved into another bedroom so that he would not hurt his wife. He noted that he had night sweats which contributed to his difficulty sleeping, and he was prescribed a CPAP machine to assist with sleeping.

Participant 067 recalled her experiences with reexperiencing the trauma. She reported that she experienced a lot of indirect fire and mortar attacks, but one incident that impacted her the most was a suicide bombers' vehicle which blew up right after entering the gates. She stated, "That just kind of set things off for me." When she returned home, she had a lot of difficulties, but she was convinced that she did not deserve help because others who had served needed it more than she. She believed there were others in need of help more than she, therefore she did not want to take resources from those experiencing greater need.; a friend of hers told her there were enough resources for everyone and that she deserved to be helped just as the others. Her experiences with reliving the trauma were frequent and extreme.

Once Participant 067 returned home from deployment she was anxious and obsessed with checking the windows and doors to ensure that they were locked. Oftentimes, she could not sleep. When she did fall asleep, she would wake up from the nightmares thinking she was back in Afghanistan. She recalled,

> I can still smell and see the gunfire, and I could feel the building shake like it shook over there after the car bombing. As a result of smelling the gunfire, I checked inside the house including all windows and doors; I checked outside around the house to see if anyone was out there. I made sure there were no wires were out of place and no fires. It sounds crazy saying it out loud.

When she reentered her house, she would check all the windows and doors again to ensure that they were locked.

Moreover, she recounted her experiences leading up to the 4th of July and New Year's as she tried to prepare herself ahead of time for the noise of the firecrackers. For these holidays, Participant 067 devised a plan that she and her family would stay home, and her husband would hold her close and talk her through the firecrackers. Last year, the firecrackers started a day before the 4th of July. Her children, ages 2 and 4, were playing in the kitchen while her husband had gone to the store. The firecrackers began popping and glaring through the kitchen window; her immediate response was to yell for the children to take cover in the hallway. The children were confused by her behavior, wondering what was wrong with her and did not move with urgency. She reported being horrified because she could not reach her husband by phone. This triggered a flashback of her buddy during deployment who was unreachable after a mortar attack; her buddy was later found on the side of the road killed from the attack.

She also reported another instance where she relived the trauma. She was out shopping with a friend on a beautiful day, and the door to the store slammed hard, she took off running to the dressing room for cover. The friend followed to see what was wrong. She stated to her friend, "The war made me crazy." Besides issues with reexperiencing the trauma, these experiences contributed to participant's difficulty reconnecting with others as she reintegrated.

Theme 2: Reconnecting With Others

The second theme focused on reconnecting. Participants share their experiences regarding their challenges with reconnecting with others. Participant 064 stated,

> I don't want your sympathy. I just want you to understand that I am different and that your patience and willingness to try and learn and understand when I say no, I hold you accountable. This is not something I ask for; when I signed up at age 17, I didn't imagine being deployed.

Reconnecting with others after returning home was difficult for all the participants as they discussed their issues with isolation, anger, lack of patience, military mindset, irritability, and suicide plans. For example, Participant 062 discussed various instances both in his personal and professional life where he had difficulty reconnecting to others. He reported he had become snappy and rude. Along with reliving the trauma, these behaviors contributed to two failed marriages. In addition, due to sustained memory loss, he had to spend time relearning previous relationships. Professionally, he reported being angry with the lack of understanding and care demonstrated by his employer for what he and other soldiers had gone through to ensure the safety of others. He stated, "I don't like people very much; I isolate myself whenever I feel uncomfortable." Participant 062 reported feelings of discomfort at work which led him to close himself off in his office and only accept phone calls from staff as needed. Further, he did not "give people the opportunity to get close to me because it has been my experience that when people find out things about you, they try to use it against you." These instances illustrated the challenges he had with reconnecting with others.

Similarly, Participant 063 had personal and professional challenges reconnecting. He discussed when he returned home from deployment, he did not have much of a family life for over a year because he was a "loner and standoffish with his wife and kids." He

also isolated himself from coworkers. Participant 064 experienced more challenges with her personal relationships. She reported several failed relationships and had difficulty relating to her children because she felt she was no longer the same person, “I’m a totally different person, but who could expect me to be the same after what I did?” Another challenge she faced as she tried to reconnect with others was her tendency to anger easily and her irritability with others and their behavior.

Participant 065 reported that reestablishing connections was the most prevalent issue he was confronted with when he returned from deployment. He stated “I found myself easily agitated, and I would close myself off. I kind of isolated myself and was in my own little world and I erected barriers which would allow those reconnections to be restored after that long absence.” He also reported that he had some suppressed anger.

Some participants' experiences with reconnecting were more intense and lasted longer. Participant 066 faced personal and professional challenges with reconnecting. He reported that upon reintegration, he experienced a lot of anxiety and anger issues, and he was very temperamental. As he put it, “I had a military mentality. When I ask you to do something, do it?” “If you're short or slack, it kind of unnerved me.” He discussed experiencing general anger as well as triggers. As an insurance agent, he needed to be cordial to customers. However, because of his anger, he was short with customers and realized he needed help. In addition, he physically and verbally acted out on occasion. In several instances his anger got the best of him, and he had trouble acquiring employment.

On one occasion he became angry with the lady from the food stamp office when he was trying to secure food stamps for his family because he was out of work. She told

him he did not qualify. Participant 066 believed he should qualify since this was the first time since he was 16 years old that he had been unemployed and not paying into the system. He told the lady from the food stamp office, “You can’t give me a damn $155.00 for a bag of groceries for my family, and I’ve been to war 3 times; excuse my French, y’all keep that damn money.” He slammed the phone down, tore it off of the wall, and put a hole in the sheetrock.

Participant 067 discussed how difficult it was to be around other college students when she returned to college after her deployment. She said, “They were kind of catty,” and she was not used to that. She was used to people working as a team, “but here people wanted what they could get out of you.” This led to self-isolation, “I didn’t want to be around anybody for real and didn’t want to be involved in drama or mess.” She found herself quick to anger without understanding the cause; “I would get so frustrated, and the anxiety led to more anger and frustration.” She realized from the information she was reading or hearing, she could have PTSD. She faced several challenges before she was willing to seek help, which resulted in a diagnosis of PTSD in 2019.

The inability to reconnect with others was detrimental to the overall health and welfare of the participants. In fact, Participants 062 and 066 both discussed suicidal ideation. Participant 062 reported that an inability to sleep and focus in combination with his failed marriages, the issues he experienced with his job, the loss of memory, having to relearn how to do things he had done prior to deployment, relearning people in his circle of friends, and his drinking as a way to cope had put him in a place where he “could not tolerate the way I was in my life.” He came home on a weekend furlough from Fort

Benning and sat cleaning his gun, planning to kill himself. His wife called Fort Benning Behavioral Medicine and they contacted a local hospital that picked him up, put him in a straitjacket, and admitted him. He stated that he threatened to "kill everybody in the damn hospital." Following his hospitalization and new medication regimen, he returned to his military base where he was restricted. He reported they were assessing him and would not release him because "they did not know what they were releasing, I was totally, totally out of control."

Participant 066 reported nightmares, night sweats, anger issues, anxiety, and drinking as a coping mechanism. These experiences, in combination with financial hardship, contributed to suicidal ideation. He was frustrated with a system he viewed as one that failed those who needed help. Due to his anger he was deemed unemployable; the doctor at the VA felt that he would not be able to be supervised and that he did not qualify for vocational rehabilitation. He called a friend and told him he had decided to end it all and designed a plan to end his life that would still provide financial support for his family. He reported "being worth more dead than alive." He had decided that on Saturday morning he would drive to the mountains where he and his family had often vacationed and drive over the cliff. The day before he was to enact his plans, he received a letter awarding him full disability and benefits.

Theme 3: Difficulty Performing or Maintaining Employment

The third theme focused on the challenges of performing and maintaining employment. According to Participant 064, "Employers need to be aware of the needs of service members as they reintegrate back into the civilian workplace." All the

participants were employed prior to deployment. Some maintained the jobs they had before deployment while others changed or retired from their job, but all had experienced some type of reintegration issues regarding their employment. The challenges described in this section illustrated what the participants experienced concerning their work reintegration process.

Participant 062 served his country for 27 years through full-time active duty and the Reserves only to return to a hostile work environment. He reported having difficulty focusing on the task at hand if he had a sleepless night and nightmares that seemed to stick with him the next day, but his supervisor was understanding due to his previous work history and his tour of duty. The hostile work environment came from the human resources director and another employee.

Stigmatizing mental illness among veterans can result in discrimination by people in power such as employers and landlords (Mittal et al., 2013). Participant 062 discussed a series of discriminating events he experienced upon his return to work. At the time he returned from his final deployment, a soldier at Fort Hood in Texas had gone on a shooting spree on the base and killed people. An employee reported she was afraid that he would do the same. Even with his exemplary work record and no evidence for the complaint, he was asked to have a psychiatric assessment. He was cleared and determined to be fit to return to work by three different psychiatrists; however, he was asked for his military records and a fourth assessment by the human resources director. He told his employer that he could not get his military records, yet the human resources director indicated non-compliance would result in dismissal. He told human resources

that he was not going to have another “damn assessment. Either give me my job or fire me.” Participant 062 informed the VA of the issues relative to threats of termination to which they responded that the company would regret taking such actions. In addition, he reported that one psychiatrist claimed his employer wanted him declared unfit to work. Despite multiple experts declaring him fit, the harassment continued. It did not stop until the Board of Directors determined he was not a danger due to his exemplary work record and a lack of evidence indicating he was a danger to others. This experience contributed to his dislike of and inability to trust others. He concluded, “People will use what they know about you to hurt or destroy you.”

Participant 063 reported being employed at a plant where production was a factor, and he needed additional time to adjust to new equipment and procedures. For him, dealing with people, in general, was difficult as others wanted to engage in conversations that questioned orders rather than simply following them as one would do in the military. However, for Participant 063, the greatest concern was his extreme mood shifts. These extreme ups and downs as well as an inability to sleep contributed to long and difficult workdays. He felt no one would understand his experiences, and he began to withdraw and isolate. During his deployment, as with his job, he was responsible for others; when accidents or deaths happened on the job with his employees, it triggered him. He reported when he was at his low points at work, he would shut himself in the office and sit quietly in the dark trying to calm himself. He felt alone with no one to turn to for help.

Service members attempting to reintegrate need to feel accepted and given the time necessary to adjust to their environment. According to Participant 063, “People who

come back are not defective, it just takes time for them to adjust." Studies conducted by Burdette-Zeigler et al. (2011) and Interian et al. (2013) confirmed that the period of adjustment on the job is limited; once the service member is back on the job there is very little time devoted to identifying how well they function and if any type of modifications, assistance, or job training is needed to ensure success.

Both the literature and the participants in this study have discussed collaboration from the employer with the service member as a key component in the success of work reintegration. Til et al. (2013) conducted a comprehensive study identifying four interventions employers could use to assist veterans with mental illness with work reintegration. Those four interventions were (a) evaluate work situation—identify barriers and facilitators to work; (b) evaluate readiness to RTW—reactivate employment relationships and provide psychological, occupational, and physical conditioning; (3) establish an active commitment to RTW—reduce the obstacles for RTW and integrate progressive reintegration to work; and (d) maintain work. This study further explored supported employment which used individualized placement and support (IPS) to initiate competitive employment. The IPS were comprised of five principles: (a) the goal is competitive employment; (b) admission is based on the desire to work, no exclusions based on symptoms or work readiness; (c) rapid job searches are initiated that avoided preplacement training; (d) attention is placed on the consumer's preferences rather than the provider's judgment; (e) follow-up support it individualized and unlimited. These interventions and principles can assist in helping service members with PTSD to reintegrate into the workplace successfully.

Participant 063 and 064 might benefit from a program such as the aforementioned program when they first returned to their civilian workplaces. Participant 064 described difficulties reintegrating to work. She reported having physical and mental health issues that caused her to change jobs within the company with a significant pay decrease. She reported that she could no longer physically do the job she had before deployment due to injuries she sustained while deployed. Mentally, she was easily irritated by noises and some of the behavior of others. In her new position, she had less interaction with coworkers and the public, but the decrease in pay caused hardship.

She reported her employer made it difficult to get approved for leave time to seek help from the VA because they did not see the service members' VA appointments as a priority. She stated, "My job did not provide sick time; if you needed leave, you had to take a vacation day." She felt that service members were penalized for seeking help. According Participant 064, becoming acclimated to a different time zone is a part of the adjustment period. According to the participants in this study, this can prove to be challenging considering the limited amount of time before service members reenter their civilian jobs usually, within 4 weeks of arriving home. Programs such as supported employment might enhance employer's knowledge of accommodations and the need for flexibility when working with individuals and veterans with mental health and physical conditions that need accommodations to assist with successful reintegration in the workplace.

Participant 065 experienced personal tragedy while he was deployed to Iraq; he was sent home to attend to that situation which resulted in him having to make up that

time once he was back in the United States. He was redeployed stateside to complete his assignment, which involved a daily commute of 2.5 hours. When he returned to his civilian job, he requested reassignment to accommodate the dynamics of the personal tragedy. He was concerned that the physical and mental requirements of his job, combined with his employer's lack of knowledge regarding his military experience, could impact his employment status.

On the other hand, Participant 066 continued working the same job he had prior to deployment. Participant 066 described himself as a successful insurance agent who frequently won expenses-paid family vacations. He was deployed three times and experienced issues reintegrating after each deployment; however, the final deployment proved the most detrimental. He had trouble focusing, and it affected his job. He referenced the lyrics to the O'Jay's famous song, "My body's here with you, but my mind is on the other side of town." He explained that while he was physically present, he could not focus because he was so sleep deprived. He reported he experienced nightmares, night sweats, sleep deprivation, anger issues, and he had flashbacks of dead people; all these symptoms impacted his work performance. He described himself as becoming argumentative and curt with clients. After arguing with a client, he spoke with his district manager and asked for time off to seek treatment at the VA's PTSD unit in a nearby city. He reported several confrontations during his 3-month stay at the VA hospital. These disagreements centered around subtle incidents that he believed to be unfair treatment after serving his country.

While at the VA hospital, he reported being belittled by the staff and being cheated out of his minimal work assignment income. Participant 066 work at the VA work program where he was paid less than minimum wage; it was more of a workshop environment. He was trained by another veteran in the program; according to Participant 066 when he was evaluated by the person over the program, he left out a step in the process and was told that he would not be paid. He became angry because he needed the money and he told the supervisor over the program that how he was trained. The supervisor told him, “That’s not how I trained you”; Participant 066 said, “You are right; you didn’t train me at all, you gave me to one of your cronies to train me.” After 6 months at the VA he was discharged and he returned to work. He worked for 90 days and was told by his district manager that the human resource department had read his file and the doctor stated that he was unemployable and that he probably would not get along with a supervisor due to his chronic PTSD. He was told that the verbiage must be changed if he was to keep his job.

The participant told the district manager that this was the government, and he could not force them to change the verbiage. As a result of this report, he lost his job; he applied for unemployment and food stamps and was denied. He suffered extreme financial hardship due to the unfavorable ruling that he was unemployable. He applied for disability and some other service-related benefits and had been denied those benefits as well. He made multiple attempts to get his benefits but to no avail.

Participant 067 reported that due to the noise and the vibrations she experienced during her deployment she was unable to perform the job she worked prior to her

deployment. The noise and vibrations from the equipment were constant triggers that caused her to have flashbacks. During her deployment, she experienced a suicide car bomb at the gate of the camp where she was serving. That explosion was so intense for her that she often relived that experience. The vehicle used in the bombing was a white SUV; since that time, the sight of white SUV triggered her and she had difficulty functioning if she saw a white SUV on the side of the road. If she encountered a white SUV on her way to work, she was unable to function at work that day as she immediately began to have flashbacks. Before she got help, her family and work productivity suffered.

She experienced intense smells, room shaking, and loud noises, which contributed to her suffering. In addition, she became obsessed with constantly patrolling her surroundings to ensure safety measures were in place. These behaviors caused the participant to be sleep deprived, which affected her productivity at work and with her family. Her inability to function as she needed to in both her professional and personal life motivated her to get help. When she first sought help from the VA for her issues, she reported being belittled, disrespected, unheard, and put into a one-size-fits-all category by the counselors at that VA location.

The result of this experience led her to seek support elsewhere. She was able to find a VA location that helped increase her functioning at home and work. She reported being grateful that she had a supervisor who allowed her to make her appointments at the VA and attend them as needed which improved her quality of life. Each of the participants except for Participant 065 experienced some challenges with their employment during their reintegration process. Vogt et al. (2016) conducted a study

exploring the quality of life for service members with PTSD in three specific areas: as parent, spouses, and employees. This study confirms that there is impairment among service members with PTSD in functioning as parents, spouses and employees.

Theme 4: A Need for Knowledge Among Counselors to Develop Best Practices

Theme IV focused on the need for developing best practices through knowledge. Participant 064 commented, "If people would try to understand what we are going through, there would be less suicide. We lose someone daily. Daily, veterans are checking out."

Throughout the interviewing process, the participants spoke of their various experiences with the types of treatment and support or the lack thereof. Participant 062 reported,

> Employers need to be neutral; I mean whether it is a male or female, red, yellow, black, or white they should be forthcoming with everyone with information on how they can help you if they value the employee, they should want to do the right thing for that person.

Participant 063 reported he did not seek treatment for a long time because he did not like going to the doctor in general; when he did go and was diagnosed, he was put on medication that made him feel like he was in a trance. He reported that his belief in God, talking to his priest, and placing himself in a dark, quiet place when he begins to twitch has helped. Furthermore, he reported that having a warm, comfortable, welcoming place to go and talk with a counselor on an individual basis who genuinely cares would be beneficial.

Participant 064 reported she had difficulty in trying to get her disability benefits because of the endless meetings and paperwork that you must go through to get your benefits. There are other benefits that she was entitled to, but the process is so long and difficult that she gave up; it almost seemed like it was hopeless. Participant 064 expressed a great deal of concern for veterans and the challenges they struggle with when they come home. She reported that there is a great need for a hotline and groups for vets to go to when they are suicidal. She talked about veterans who "call in on a line where vets can call all night long talking about checking out." She expressed a need for "counselors to spend time talking to vets, not just reading textbooks; a textbook cannot tell you how it feels to have to attend mandatory ramp ceremonies for fallen comrades." She reported,

> The ramp ceremony is putting a dead soldier on the plane to send them home; my first ceremony was a 19-year-old kid who was an only child. He gave his life for a country that didn't even want him there. There are the things counselors need to understand; how these things stay with you and no one cares enough to try and understand.

Situations like the ramp ceremony are memories and scenes that a soldier will carry long after the event has passed.

Participant 065 talked about the need for education in the community and with the counselors who provide services. He reported that he believes "communities need to send community leaders to active duty installations and hold town hall meetings educating them on the variety of challenges and issues veterans experience when they are deployed

and when they redeploy." He talked about the Reserve and National Guard only being activated when there is a national crisis and they are called up and the need to "leverage resources to educate communities about what happens when they are on active duty." He also discussed the disparity in service between full-time active duty and Reserve and National Guard. Reservists and guardsmen must secure all their services, including medical, while they are called to active duty. When it came to receiving services at the VA, the service members had to obtain all of their medical records from all of their deployments on their own and hand deliver them to the VA; there is no central records system within the VA. Participants in this study indicated this can be a difficult and long process for the service member and can deter them from seeking the help they need.

Participant 066 discussed his experience with seeking mental health help during his deployment and upon his return home. During his deployment, he had a verbal altercation with one of his soldiers that he had given a direct order. The soldier refused and made a derogatory statement. He told the soldier, "You really don't know who you are messing with. I'm your worst enemy and I can kill you quicker than anything in the drug store." He said everyone in the room was quiet and the Sergeant Major asked if he was ok because this was totally out of character for him. He told the sergeant major that he was going to the sick hall to get some help. He said,

> I might as well have stayed where I was cause when I got there all he asked me were a few questions and played some music with waterfall and made me a copy of the CD and told me to follow up with the VA when I got home. Clearly, I

> needed more than that until I was back home from deployment and that was not a short period.

This was an illustration where the military needed to work more effectively with the client to ensure that he would receive continuity of care once he was home.

Once he returned home from deployment, he experienced numerous occasions where his anger caused him to act out in disputes with his family and customers on his job. This led him to seek treatment for 3 months in a PTSD unit. He tried to participate in vocational rehabilitation, social outings, and the clinical aspects of treatment. During his hospitalization, he found himself evaluated harshly for doing his job incorrectly when he reported he did it the way he had been shown to do it. His job was to wrap sanitary napkins individually and put them in a box to hand out to the soldiers who were incontinent.

He reported the VA would often carry the patients to baseball games and he chose not to go because the crowd and noise were too much for him but some of the other guys and one of his therapists thought he was being indifferent. He reported that his therapist did not know how to talk to him; she belittled him instead of trying to encourage. She was disrespectful to him as a veteran and as an older adult. He also reported during one of his session as he was describing the flashbacks that haunted him and the things he saw to his therapist, she told him that "he did not see dead people and that many of the events he described did not actually happen." He was disheartened, as he shared real events with the counselor who should have understood the type of things he might have witnessed during his deployment. He was so disheartened that he took out pictures that depicted the

horrific images he saw and threw them on her desk. These pictures showed one soldier's face being half skeleton and half flesh, another soldier was like a cyclops due to the napalm explosion, and another soldier was blown in half from his waist down. She screamed at him to take the pictures away. Later, at home after his hospitalization, he became depressed due to inability to provide for his family. The counselor he was working with tried to devise a safety plan for him by trying to get him to give his guns to his wife or a friend since he was depressed. He was resistant as he told her if his friend used his firearms on someone, he would be responsible, and he felt his wife might use them on him when he had his nightmares. After the counselor was unsuccessful in getting him to give his guns to his wife or friend he reported she looked at him and told him, "Well, have a safe holiday" and that was the end of the session. These instances are congruent with the literature and illustrate a need for more training for counselors. According to Participant 067,

> I think when you are coming back from deployment, they should have you sit down and talk to someone then, and not just try and rush you through. Like have you been here, have you been there? When you come back have you seen the dentist, have you seen the doctor, have you been to see psych? They ask you all these questions and then send you to the next place. I don't think that's ok. They need to sit down and talk to you one-on-one and see what types of needs you have and tell what types of resources are available, instead of giving us a bunch of papers that you are not going to keep up with because you are ready to get home to your family.

She reported the first VA location she went to was ineffective in helping her; she said they belittled her, made her feel crazy, and less than a human. She further reported that they seemed to try and provide services in a one size fits all manner, instead of listening to what was going on with her and individualizing a plan of action to help her. She stopped going and later tried another location and her experience was different; she was heard, respected, valued as a human, and given individualized treatment. While the experiences of these participants differ in some aspects, they all illuminate the need for better services for veterans.

Summary

Reintegration can be a long and difficult process. Reintegration refers to successful functioning in various aspects of life: (a) Psychological health—behavioral, mental, or emotional symptoms or disorders, or psychosocial functioning; (b) Physical health—disease, injury, illness, or wellness; (c) Social—interaction with family, friends, parental or marital relationships; (d) Employment—postmilitary unemployment or jobs; (e) Housing—homelessness, shelter/accommodations; (f) Financial—personal economic situation; (g) Educational—college, continuing education at school; (h) Legal—illegal behavior or criminal justice matters; (i) Spiritual—religious or spiritual activities or sense of meaning in life; and (j) Non-specific-functioning—psychosocial, health, or community-related (Baysinger , 2015; Elbogen et al., 2012; Elnitsky et al., 2017). The participants in this study have experienced one or more of these components as they reintegrate into their predeployment lifestyles, except for legal.

They gave details regarding their mental health challenges from outpatient treatment with therapists, to hospitalizations and group therapy. Participant 064 reported that her physical challenges caused her to change jobs within the company she was working for before deployment for less pay. All participants reported challenges with social components concerning family, friends, parental, marital, issues. Participants 062 and 064 stated they had failed relationships and marriages. Participants 063, 065, and 066 reported they had difficulty in their marriages and reconnecting with others; Participants 064 and 066 reported having physical altercations with their children.

Returning to work after deployment posed different challenges for each of the participants; in some cases, jobs were lost, their positions were changed, and there was a decrease in income for one participant. Participant 062 maintained his job with his employer, but it came at a great cost to him with all of the psychological assessments he went through and threats of termination if he did not provide his military records. Participant 063 reported he had to adjust to new equipment and new procedures. Participant 064 was unable to physically and mentally perform her previous job, so she had to take a decrease in income. Participant 065 reported no challenges with his employment. Participants 066 had difficulty with anger and inability to concentrate when he returned to work. His manager was supportive of allowing him the time off to seek treatment. Participant 067 experienced difficulty concentrating if she saw a white SUV on her way to work; both Participants 066 and 067 had supportive managers that made seeking treatment easy. The effects of deployment can be devastating and service members who develop PTSD struggle to put their lives back to a predeployment state.

Deployment and PTSD are common denominators among these service members as in the aforementioned study by Lancaster et al. (2014). The service members' ability to perform their jobs as a result of PTSD has been impacted. Employment is an essential part of these service members' lives.

The roadblocks these service members had endured regarding their mental and physical health care challenges, their relationships with family/friends, the community, and especially their employers must be demolished. We can demolish these roadblocks through education, understanding, training, funding, and policy changes that come down to the development and implementation of best practices for all service members. Chapter 5 provides the Interpretation of the findings, the limitations of the study, recommendations, implication for social change and the conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to understand the lived experiences of service members with PTSD who face employment challenges while seeking to reintegrate into the workplace. I conducted a hermeneutic phenomenological research study using face-to-face semistructured interviews with six participants. The responses from the participants provided rich, thick data about their experiences of reintegrating into the civilian workplace. The detailed account of their experiences contributed to the understanding that there is a need to develop best practices to serve this population. The key findings of this study reinforce that the development of PTSD has a lasting impact on the mental health, relationships, and employment of service members who have been deployed. In this chapter, I discuss the findings in relation to the literature review and the theoretical framework. The chapter also includes a consideration of the study's limitations and implications for positive social change, recommendations for best practices and future research on the topic, and a conclusion to the study.

Interpretation of the Findings

In accordance with the literature review, the findings confirmed that service members who had been deployed were likely to develop PTSD, which, research shows, is associated with service members encountering challenges upon their return home (Lancaster et al., 2014). Those challenges are reflected in the themes in this study: reexperiencing the trauma, reconnecting with others, difficulty performing and maintaining employment, and a need for knowledge and the development of best practices for counselors. The *DSM-5* outlines the behavioral symptoms and the four

specific clusters that constitute criteria for PTSD. Those clusters are reexperiencing, avoidance, negative cognitions and moods, and arousal (APA, 2013). Reexperiencing encompasses recurrent dress, flashbacks, spontaneous memories, or intense or prolonged psychological distress (APA, 2013). The findings of this study confirmed some of the behavioral symptoms identified in the *DSM-5* for PTSD, such as nightmares and flashbacks. Participants repeatedly mentioned recurring symptoms such as nightmares, sleepless nights, flashbacks, and night sweats, which contributed to their physical and mental health issues. Oftentimes participants experienced the trauma during their daily routine due to triggers such as a smell, a certain type and color of SUV, or a weather siren. The recurring symptoms also contributed to issues with reconnecting with others, including their employer.

PTSD affects the whole person (Burke et al., 2009; Meis et al., 2010; Wehman et al., 2009). Service members who have been deployed often return home with physical, emotional, and psychological impairment (Burke et al., 2009; Loughram, 2010). In this study, participants discussed challenges with reconnecting with others. This finding supports others' findings that service members who have been deployed often experience difficulty in their relationships, whether they be intimate, parental, professional, or social (Vogt et al., 2016). Participants in this study also discussed the challenges they faced with family and friends as they found it difficult to communicate, and they sometimes became easily angered and irritated with others. Previous researchers also found that service members who returned from deployment in Afghanistan and Iraq indicated a poorer satisfaction with work and family and were less able to be a parent, spouse,

partner, or employee (Vogt et al., 2016). According to Ashern et al. (2015), the homecoming theory, which was developed after WWII to serve as a framework to understand the challenges of transition from military service to civilian life, describes disconnection or alienation as a challenge among service members upon their return home due to the separation from home by time and space, which results in changes in the service members' environment. The findings in this study confirmed this disconnection or alienation as participants reported instances where they isolated themselves from their families and friends upon returning home.

Further, participants in this study discussed reintegration challenges with their employment. The challenges ranged from a hostile work environment, having to learn new procedures and how to operate new equipment without any accommodations, having to change job positions for lower pay due to inability to physically or mentally perform their previous job, feeling alone and depressed, being unable to concentrate because of a trigger in the workplace, and encountering an inability to get leave for VA appointments. According to Burnette-Zegiler et al. (2011), individuals with psychiatric disorders averaged a loss of 6 days per month per 100 people, and the number of cutback days was 31 days per month per 100 people among the general population with psychiatric disorders. Veterans having a psychiatric disorder are less likely to work, and depression and PTSD have a significant effect on the hourly rate (Burnett-Zeigler et al., 2011). The findings in this study confirmed that more workdays and work hours are lost for service members with PTSD and co-occurring mental health issues such as depression.

PTSD seems to be an important predictor of unemployment, especially when the

symptoms increased (Burnett-Zeigler et al., 2011). There are few studies on service members who are unemployed and were involved in OIF/OEF. Studies conducted to examine service members' employment status and to identify functionality issues regarding employment and job training revealed that the window of time to reenter their civilian employment is small (Burnett-Zeigler et al., 2011; Interian et al., 2012). The findings of this study confirmed that the reentry time for service members to return to work after deployment is not adequate. However, there is limited knowledge about how to reintegrate individuals with mental illness back into the workplace after a prolonged absence, and even less is known about how to reintegrate veterans (Til et al., 2012). Participants in this study confirmed that there is a great need for counselors to learn about their needs and develop individualized treatment and support to assist them.

The findings of this study revealed there is a need for more research to show counselors how to work with service members who are reintegrating back into the community and workplace. The literature revealed that there is anxiety associated with service members leaving home, a need for constant guidance with daily routines, and that many of the skills used during their deployment were not transferable (Kramm & Heinecken, 2015; Orazem et al., 2017). The findings of this study disconfirmed those in the literature review. In this study, I found that there is some anxiety when trying to navigate what to do in different settings and how to relate with different individuals, but I did not confirm that there is anxiety in general when leaving home; I further found that service members performed their jobs with a sense of urgency and without question; whereas civilians do not always work with a sense of urgency. Lastly, this study

disconfirmed that service members do not require constant guidance with daily or work routines.

The findings of this study revealed that there is a need for workplace support to assist in reintegrating service members into the workplace. Moreover, it is difficult to access services through the local VA system once a veteran has completed deployment. Participants reported that it is imperative to begin the process before the end of the tour because those services are time limited when dealing with an injury that is associated with the tour of duty or deployment. Participants also reported that they are on their own in trying to access all of the necessary paperwork they need to carry with them to the VA regarding any treatment they have received during their deployments.

Lastly, there is evidence that additional training is needed for counselors and future counselors to work with service members with PTSD who are experiencing work reintegration challenges. In this study, I began to illuminate the need for best practices that provide awareness, education, understanding, and knowledge among counselors and future counselors in working with this population. For example, participants in this study mentioned that they were appreciative that someone was trying to better understand what they had experienced and what they needed to help them readjust to their communities and jobs. They emphasized a need for counselors to have a willingness to learn about their problems and include other veterans in their quest for understanding. Participants wanted counselors who were willing to put in the work by learning firsthand the issues they face, not just reading about the problems. They wanted counselors who want to work

with veterans who need and want to tell their stories to someone who they perceive as genuinely wanting to hear and help.

Limitations of the Study

The limitations of this study include the small sample size. Although the sample was six participants, I did obtain data saturation. According to Cohen et al. (2000), saturation occurs when the researcher has enough data to have a complete description of the experience being studied. The size and subjectivity of my study might not be able to be generalized to other branches of the military; however, it can be used as a foundation to influence other studies that can contribute to broadening the knowledge through understanding and meaning. Another limitation of this study is that I specifically focused on service members who served in Afghanistan or Iraq or both and who had a diagnosis of PTSD. The perspectives of other service members who might not meet these criteria could differ. Lastly, my role as a researcher could be another limitation. My initial interest in PTSD among service members stemmed from two clients I had in my private practice before entering the doctoral program. Therefore, I needed to bracket my personal views and emotions during and after the interview process to ensure that my thoughts and opinions had no part in the results of the study.

Recommendations

This study served to promote understanding and awareness of these lived experiences for counselors, army leaders, family members, employers, and the communities of service members. It also gives a voice to Army Reservists and National Guardsmen regarding their perspectives on how to best serve this population. The

recommendations of this study directly tie into the development of four best practices indicated in Chapter 4. Best practices include the development of a veterans' advisory board to partner with the VA and the need for counselors to provide veterans input on treatment, resources, and support services.

Counselors need to create a safe, warm, and inviting environment for service members to come to when seeking help. Counselors and the VA can start by being respectful and sensitive to the individual needs of each veteran. The VA needs to assist the service member in accessing their service treatment records during their time of deployment. Service members throughout the interviews mentioned the difficulties they faced in trying to obtain their medical records from the places where they have been deployed and having to hand-deliver them to the VA for services. In addition, participants described issues navigating the process of filing for disability due to their service-related injuries and the timeframe for filing these claims. This is confirmed by the literature review, which indicated that service members who were deployed are eligible to use the VA system services for up to 5 years at no charge for services related to issues or injuries sustained during their deployment (Sayer et al., 2015).

Counselors need to learn the language of the military, which begins to bridge the gap regarding developing a basic understanding of what the service members discuss. ss. Participants in this study highlighted experiences in which their counselor was unaware or unfamiliar with the language used to illustrate presenting issues. Counselors who specialize in the treatment of veterans need to learn basic terms, rank, acronyms, the process of deployment, and redeployment. In addition, in concordance with ethical codes,

counselors should learn what community resources are available to veterans and their families. By partnering with veterans and the VA, counselors can develop a greater understanding of the military to increase rapport building among service members as they seek treatment.

Developing peer support groups for veterans and their spouses to assist the spouses while the service member is deployed and to assist them both during the reintegration process may be helpful. Counselors can attend these groups if invited to learn more about Army culture and the needs of this population and to assist them. Counselors could assist veterans and their spouses by identifying community resources and by advocating on their behalf with agencies, health care professionals, and in the community at large. I also recommend developing a group of veterans who will serve in the community as peer consultants for employers. These veterans would work specifically with employers who have service members who are returning from deployment. This group would educate the employers on the deployment process and how service members adjust after deployment as well as the support needed to assist in the reintegration process. They could also give tips to the employer on the signs that might indicate service members need help with adjusting to the procedures, coworkers, or any area that might impact service members. This group would also be available to come in and talk to the service members so they do not feel alone during the reintegration process.

The focus of this study was to illuminate the lived experiences of service members with PTSD who have been deployed and are trying to reintegrate into the

workplace successfully. Employers need to understand the tough choices service members make regarding their full-time civilian employment and their Army Reserve or National Guard service duty. Employers need to be educated regarding the challenges they face regarding coworker relationships, the work environment, time off for VA appointments, time to acclimate back to the time zone once they return home, and a different type of work culture than the military. Veteran peer consultants can be a valuable asset in the civilian workplace as they serve as a liaison for the service member and the employer to foster an understanding of the reintegration process.

One of the recurring concerns for the participants in this study was the difficulty they experience when trying to take time off for VA appointments. One way to address this concern is to develop and implement banking time for veteran's programs in the workplace. Banking time for vets would entail civilian employees and the executives of a company to bank an hour or a day of time from their sick or annual leave time into a veteran's VA pool for therapy and doctor's appointments. Individual companies could decide if the time donated is on a quarterly or annual basis; this could also serve to show appreciation to veterans for their service. This recommendation confirms peer support networks among veterans to promote meaningful rehabilitation for individuals with PTSD in their work experiences (see Harris et al., 2017). Lastly, counselors, the VA, and veterans should develop and implement quarterly roundtables for the community. Churches, schools, or other civic organizations can hold public roundtables for service members to educate their families, community leaders, and the public on the challenges service members face with reintegrating into the community. During these roundtables,

veterans can share their stories, and counselors can share resources and advocate on their behalf. Counselors who provide services to service members should establish partnerships with the VA and other agencies serving veterans. They should also attend as many community and professional veteran events as possible to gain the necessary knowledge to effectively assist this population. Counselors should never minimize the service members' experiences and should express gratitude for the service provided by service members. In this study, I identified specific best practices counselors can use to increase their competence as there is a need for additional research that can further promote change not only among counselors and future counselors but also among the military and policymakers.

Implications

Ultimately, this research study and the recommendations could improve how counselors provide services to service members with PTSD and who experienced challenges reintegrating postdeployment. Many service members will return home to areas that are not readily accessible to community resources or VA services needed to address the various issues they may encounter, such as mental health, family and parenting, marital relationships, finances, and employment. These service members are marginalized (Resnik et al., 2012), and this study can provide information to assist those who are marginalized.

The findings of this study can be used to increase counselors and counselor educators' knowledge, and in the training of future counselors; which enhances their ability to effectively advocate on behalf of service members. Additionally, this study can

broaden the awareness of employers, army leaders, families, and community leaders of service members regarding the challenges and needs of service members when returning from deployment.

Conclusion

OIF and OEF were the longest wars that the United States has ever fought. It has been reported that this war generated over 2 million U.S. military combat service members; over 1 million have been diagnosed with one or more mental health issues (Ursano et al., 2016). The 1 million service members diagnosed with mental health issues is not reflective of those who have yet to seek treatment. In this study, I focused on the impact of PTSD and how it impacts employment among service members. PTSD affects every area of the service member's life socially, emotionally, psychologically, physically, and financially. When service members return home, many are impaired and experience public and private challenges that need to be addressed, especially in the mental health arena. In this research study, I have highlighted the trauma experienced by service members with PTSD, the difficulty service members have with relationships and employment issues, and the need for knowledge among counselors on how to develop and provide best practices to assist service members with successful reintegration. As change agents, counselors must be willing to examine competence in effectively serving this population. Further, counselors must be willing to do the work necessary to serve this population in the best way possible; this begins with caring enough to listen not judge, to learn not to teach, and to create a safe environment for this population. Counselors must develop a working knowledge to work with this population, just as they work within their

areas of expertise, they must develop the skills necessary to work with service members. Counselors can make a difference by partnering with agencies serving veterans, community leaders, churches, employers, and the VA to work with and on behalf of service members to ensure they come home to a place of peace, not an ongoing battle.

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Appendix A: Interview Questions

Tell me about your family life, specifically, your marital status and are you a parent?

Have you experienced any difficulties reintegrating back into your roles as a ____ in your personal life?

Tell me about your deployments, specifically about your locations, the duration, and how many deployments?

Were any of the deployments more difficult than others and if so how and why?

Prior to your deployment how would you describe your health? Did you have any physical or mental health concerns?

Since returning home what type of reintegration challenges have you experienced?

When were you first diagnosed with PTSD? More specifically were diagnosed while deployed? If not how long after your return?

What type of treatment or supports have you received?

Prior to deployment what type of work did you do?

Since returning home have you returned to your previous job and if so how is it going?

Have you experienced any difficulties with working in the civilian workforce? If so, please describe?

What type of support do you think you need to successfully reintegration back into the civilian workplace?

Appendix B: Recruitment Letter

To Whom It May Concern:

My name is Donna Sargent, I am a doctoral candidate at Walden University's Counselor Education and Supervision Program. I am a Licensed Professional Counselor with a local private practice. I am a provider with Military One Source.

I will be conducting a research study for service members with posttraumatic stress disorder (PTSD). The title of the study is "Service Members with PTSD Who Are Experiencing Work Reintegration Challenges." The purpose of the study is to gain an understanding of how to best serve service members who have been deployed to Afghanistan or Iraq or both with PTSD; who are experiencing difficulty with reintegrating back into the workforce. These service members must be Alabama Army Reservists or National Guardsmen.

Participants will include Army Reservists and National Guardsmen from the state of Alabama and the population for this study will range in age from 18-59. The participants may include both male and female service members from all ethnicities who meet the inclusionary requirements and are willing to participate. The prerequisites for participation in this study include (a) service members who deployed to Iraq, Afghanistan, or both for 6 months or longer; (b) service members must have a diagnosis of PTSD; (c) self-identified as currently experiencing problems with work reintegration, and (d) must be an Army Reservist or National Guardsman from Alabama.

I am asking your assistance in making announcements in your place of service and send the information out through your listserv. I would also ask that you allow me to post flyers. All information is confidential. The flyer will include the name, purpose, and contact information. Individuals who are interested will contact me via email where the purpose of the study will be given, informed consent including the risk and benefits of the study and their right to withdraw at any time without reprisal will be presented and explained fully to all who inquire about the study.

I would appreciate the opportunity to give a voice to the challenges many of our service members face as they return home; and try to make their transition back into the workforce a successful one. Thank you in advance for your consideration of this manner.

Respectfully,

Donna Sargent, MS, LPC-S

Appendix C: Recruitment Flyer

Study for service members with PTSD.

We're looking for adults between the ages of 18 to 59 who suffer with PTSD to examine best practices in returning to employment in the civilian workplace after deployment.

Participants will be asked to participate in :

- 1 individual 90 minute interview
- 1 follow-up meeting to verify information after all data has been collected

Location

Interviews will be in Birmingham ,AL and Jacksonville, AL. The location will be disclosed to participants only to protect the confidentiality of participants.

Are you eligible?

- Must be an Alabama Army Reservist who was deployed to Afghanistan or Iraq for 6 months or longer
- Must have a diagnosis of PTSD
- Must be between the ages of 18 to 59
- Must identify as having employment issues

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